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visions

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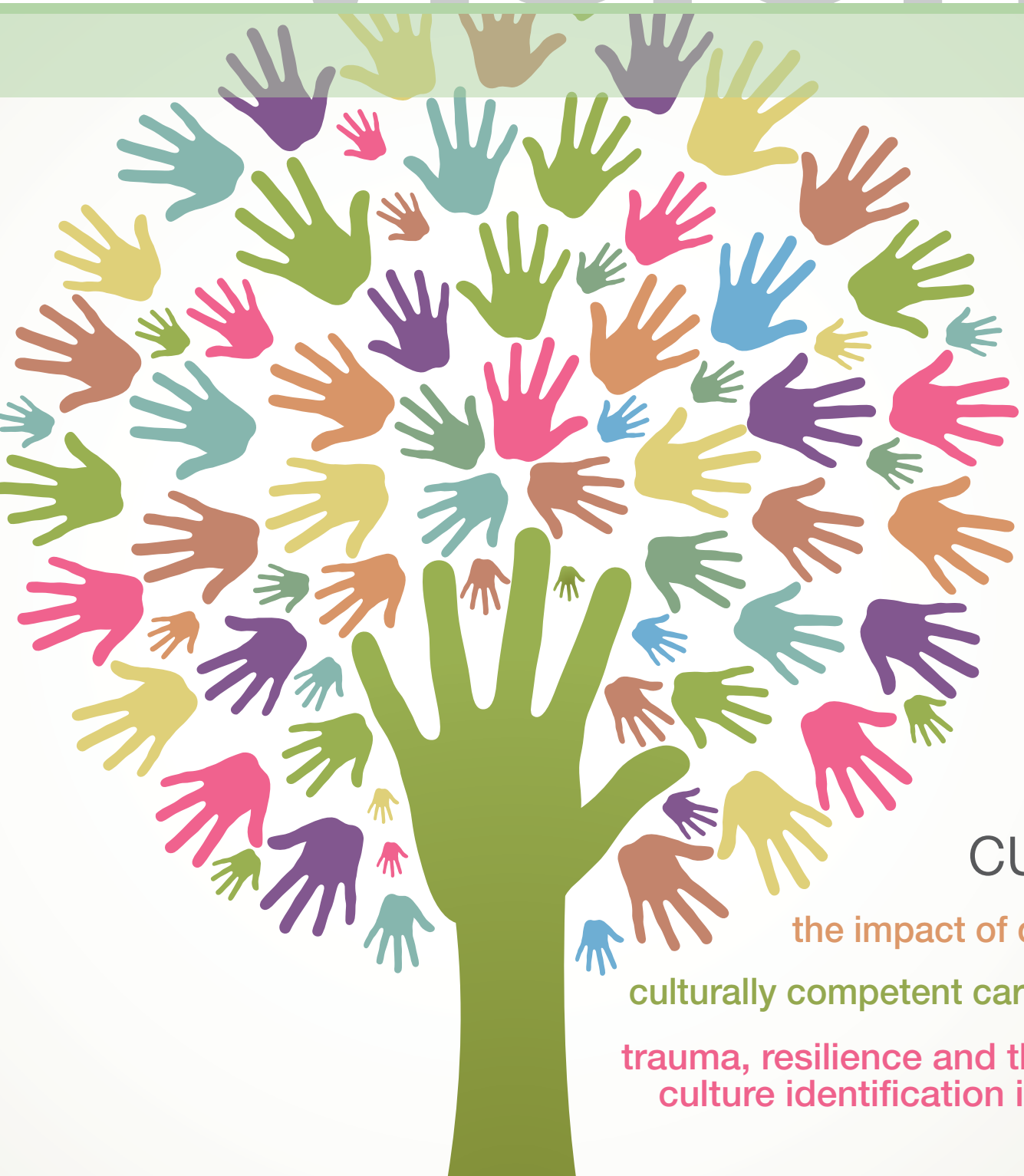

culture

the impact of difference

culturally competent care for men

trauma, resilience and the role of culture identification in healing

visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental illness or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Substance Use Services, an agency of the Provincial Health Services Authority.

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Heretohelp is a project of the BC Partners for Mental Health and Addictions Information. The BC Partners are a group of seven non-profit agencies working together to empower people to improve their quality of life by providing useful, accurate and good quality information on mental health, mental illness, substance use and addictions. We represent AnxietyBC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health, Family Services of the North Shore's Jessie's Legacy Program and the Mood Disorders Association of BC. BC Partners work is funded by BC Mental Health and Substance Use Services, an agency of the Provincial Health Services Authority. Visit us at **www.heretohelp.bc.ca**.

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background

experiences and perspectives

alternatives and approaches

*pseudonym

letters to the editor

I am absolutely head-over-heels thrilled and happy with the publication of my article in *Visions'* Recovery issue. It is truly an honour to be in your award-winning publication. Being published in *Visions* has been a very uplifting and confidence-boosting experience for me. The genuine respect for my lived experience by *Visions* staff, with a venue for my voice, certainly strengthens and enhances my recovery from mental illness. If I reached just one person suffering with OCD—who now knows that hope and recovery are possible—then my work is done.

—Doreen Gee, Victoria

I have been attending counselling at Penticton Adult Mental Health and that is where I have been reading your magazines. I find them supportive in dealing with my own mental health issues—bipolar disorder II, PTSD, and borderline personality disorder (BPD). I have recently been grappling with acceptance and understanding of my recent diagnosis of BPD. There is a long family history of mental illness and addiction on both sides of my family and I struggle with relationships with two family members, one who has addiction and concurrent schizophrenia and has often been homeless in the BC Interior. Another family member has many issues: chronic pain, major depression, anxiety disorder and I could go on. My partner and I just had an overnight visit with my family member in Kamloops. I send copies of articles to him. It was a good visit but leaves me exhausted and emotional. Thank you for your magazine, the many articles and contributors who aid all of us who suffer, have to go out daily in the "fray" and not only try to care for ourselves but where the onus is on us to care for our family members. Peace to all and goodwill.

—Sheila, Penticton

editor's message

Norm: A belief held by a group about how to behave in a particular situation. A bit of jargon until you realize it's also the root of a word that we encounter pretty often: *normal*.

As you'll read in the guest editorial, this issue of *Visions* had an ambitious goal: we wanted to look at our Culture theme broadly. Of course, culture has always been bigger than ethnicity. It's about identity, belonging and informal understandings about how things are done. It's also about who defines what is normal, and whose well-being is impacted as a result.

Like the idea of 'normal,' stigma is relative. Stigmas are imbedded in culture, and both stigmas and culture can change—ideally for the better. It would serve the mental health field well to study the culture and stigma shifts in areas like cannabis, tobacco, drinking and driving, cancer or LGBT rights.

How many times have we heard—as service providers or family members—the phrase, 'you just don't get it.' It may be that we're poor listeners but it's just as likely that we are from a very different cultural group from the speaker. Maybe it's a generation gap, or a gender gap, or a class gap, or a disability gap, or an ethnicity gap. Or a combination of gaps. We simply don't have the shared history, understanding, language, or ways of being. But even if we did in one area, we can't be a member of every culture. So we need to find ways to bridge the gaps. Respect, humility, curiosity, and empathy go a long way in improving understanding and providing culturally competent care.

Teach-back is one technique to help in understanding. For example, a family doctor might ask a patient at the end of a visit to summarize what they understood. Teach-back reduces misunderstandings and aids memory. In planning and reading this issue, it strikes me that it would serve all mental health and addiction professionals to do teach-back in reverse. That is, to listen to their clients share their realities from their cultural perspectives and at the end of a visit, summarize what they have learned in a way that makes sense to and honours the client.

Sarah Hamid-Balma

Sarah is Visions *Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division*

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

The Impact of Difference

Guest Editor Natasha Aruliah, MEd

It is a pleasure and great honour to be guest editor for this culture-themed issue of *Visions*. In both my professional and personal life I have found that culture has profound impacts on people's lives, and yet—like breathing and the air itself—it's so often invisible and unconscious to us.

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Natasha is a Psychologist, in intercultural, couples and family therapy. She has worked with international students, immigrants, refugees, youth, aboriginal people and people of colour in a variety of settings in Canada and Britain. Currently, she is an independent consultant in diversity, equity and social justice. She facilitates courses in the UBC Certificate in Intercultural Studies, delivers courses at the Justice Institute of BC, and is a guest lecturer at the Vancouver Art Therapy Institute

Skimming through this *Visions*, you might wonder why it claims to focus on 'culture' when there are so many articles on diverse topics such as youth, indigenous people, men and the influence of pop culture and media. Well, this issue embraces a broad definition of culture, which recognizes that cultural groups are not limited to just racial, ethnic or religious groups.

Most definitions of culture state that cultures are shared by a group of people and define the group's values and beliefs, ways to behave and how they organize themselves. Culture is said to be passed on between members of the group, learned and reinforced by them. It is always changing, rather than being fixed or rigid.

This broader definition includes many groups other than ethnic, racial and religious groups; groups with other commonalities such as gender, sexual orientation, regional, generational, professional or class identities. Examples include working-class, East coast, business, health-care, hip-hop or youth cultures.

This broader definition also means that we all belong to more than one cultural group. For example, I could be viewed as Sri Lankan, but I am also a woman and at times it is that 'gender culture' and identity that might inform my experience and behaviour in a given moment and not my Sri Lankan culture. At other times it may be my professional culture and identity that is more relevant, or my generational/age culture and identity. Additionally, each of these identities can be viewed and experienced individually (i.e. something in common with all women)

Most cultures communicate to members that mental illness is a taboo subject, not to be talked about publically, but in private, behind closed doors, in hushed voices—that somehow being mentally ill is shameful and wrong.

or can intersect with other identities. For example, being a South Asian woman has a specific experience that is different to being a South Asian man or being a white woman.

Unconscious bias

Culture is mainly unconscious. We are born into or choose to belong to certain groups, and therefore learn how to behave as members of those groups, but this can happen in very subtle ways. Behaviours are taught by example, and we are instructed both overtly and covertly as to how to behave and what is acceptable or not within the group. How and what is considered rude behaviour can be explicitly told to us—"don't talk with your mouth full," "don't spit"—or implicitly by stern looks from parents or others when you do something they don't approve of without naming the 'bad,' unacceptable behaviour.

Thinking about this and its implication in mental health, most cultures communicate to members that mental illness is a taboo subject, not to be talked about publically, but in private, behind closed doors, in hushed voices—that somehow being mentally ill is shameful and wrong. And while we all know these 'rules' of our culture, did anyone explicitly tell us this was the rule?

In teaching behaviour it is implied that everyone would recognize a specific behaviour as the 'right' behaviour. This is often at the root of stereotyping and bias and has huge potential for miscommunication. Based on our learned cultural values and beliefs, which we think are universal, we evaluate and judge others—usually unconsciously—when they behave differently. However, what is right or wrong behaviour to one group or culture is not necessarily right or wrong to all. Being loud or emotionally expressive, for example, might be rude for some groups/cultures and not for others.

Additionally, failure to recognize that many people have complex and multi-layered cultural identities also contributes to bias. Using my example as a middle-class, educated, UK born, Sri Lankan, immigrant woman, I am often treated based on stereotypes of South Asian women. Assumptions are made about how 'traditional' I am; how little autonomy I have as a woman, having an arranged, loveless marriage; I even get comments on how good my English is and so on. These assumptions about me fail to recognize that even in my racial identity, not all South Asians are the same and that there is great diversity within 'brownness.'

As practitioners and service providers, we all hold some degree of unconscious bias, which can impact our behaviour.[1] Research has demonstrated that when we have high levels of unconscious bias, the more likely it will influence our behaviour. For example, emergency room doctors who held high levels of unconscious bias were less likely to provide life-saving treatments to African American patients than white patients, despite believing that they treated everyone equally.[1] In Canada, we only have to consider the experience of our indigenous people, or people who are addicted, mentally ill or homeless to see how bias can impact services. The research also demonstrated that, while we all have unconscious bias, we have the ability to reduce our bias and therefore change our behaviour.

Why is it worth focusing an issue on broadly defined culture?

There are a couple of compelling reasons for me. Thinking about culture in this broader way moves us from seeing cultural groups as just ethnic or religious groups and recognizes we all belong to numerous groups, which all influence our behaviour and worldviews. It allows us to introduce notions of belonging and identity and recognize that in belonging to many groups and cultures we have rich and complex stories and identities that shouldn't be reduced into one piece that is visible, assumed or stereotyped. When parts of who we are and how we are identified are denied or devalued in society it has potential impacts on

our sense of belonging, self-esteem and potentially on our mental well-being.

Also a broader definition raises awareness and questions about power and influence. Our cultural identities, however complex, are also connected to power and access. Some groups and cultures hold power and influence, and others do not, which can also impact our sense of belonging and our self-esteem.

Defining wellness

In recognizing the pervasiveness of cultural/group values, it stands to reason that definitions of wellness and health are culturally-based. When we think about notions of 'deviant' and 'abnormal' behaviour as possibly being expressions of culture values and ways of being, then the question of health and wellness can be challenged. Who gets to define wellness becomes an important question. Are we approaching health and wellness from a limited mono-cultural view that excludes other perspectives?

The dominant cultures are the ones with power and influence, so they get to define (based on their own cultural values) what is 'right' or 'wrong' behaviour. For example, in a male-dominated society, women tend to be labelled based on 'male cultural norms.' An obvious example is the cultural differences between how men and women experience and express emotions. In general, regardless of ethnic or other cultural identities, men are socialized to be less emotionally open and expressive than women and are the dominant group, allowing them to set the norms and standards, and thus we see women labelled 'hysterical' or 'overly emotional.'

When we, both as cultural group members and as practitioners, think about health and well-being, our unconsciousness about our own cultural worldviews can lead to misdiagnosis and labelling. If our culture tells us how to behave, then those who don't behave the way our cultural group defines as the 'right' way run the risk of being labelled as 'bad,' 'wrong,' 'deviant' or 'abnormal.' The non-dominant or marginalized groups, whose ways of being are merely different, are often labelled as deviant or wrong.

Although culture tends to be unconscious and yet has huge influence over our behaviours, the fact that culture is always changing and that individuals and groups can change is important. As we learn more and raise awareness we are transforming ourselves, our organizations and our society. In particular, recognizing and learning how our cultures influence us, about different cultural groups and their perspectives, and the power and influences of dominant groups helps us move from providing services based on dominant-group values to more inclusive and appropriate service provision for all.

So, as you read through this issue, my question and challenge for all of us is to reflect on whose cultures and values are being reflected, whose voices are being muted, and what the impact of that is. How can we provide appropriate interventions and services in all this diversity? There is so much more to say on this subject—it is, after all, just the tip of the iceberg. But I hope this *Visions* stimulates you and provides food for thought and action. V

So, as you read through this issue, my question and challenge for all of us is to reflect on whose cultures and values are being reflected, whose voices are being muted, and what the impact of that is.

Trauma, Resilience and the Role of Culture Identification in Healing

Kimberley Work, BA

Culture provides a larger sense of who we are, where we come from and where we belong. Culture can provide us with a lens through which we frame, relate to or understand events. A culture doesn't have to be defined by racial or ethnic background.

Kimberley is a counsellor and advocate in Vancouver. She has worked in the justice and health care fields for and with individuals who have experienced trauma. In her personal life and professional practice, Kimberley has experienced and witnessed the role culture plays in increasing wellness for individuals, family, communities and Indigenous nations (also known as Aboriginal peoples)

It can be identified by where the person's heart sits, or where they feel the most understood or the greatest sense of belonging. We can participate in and belong to many cultures, though we usually identify mainly with one. When we look at culture this way, it becomes a very fluid entity, applicable to all people.

Canadian people of Caucasian descent have often said to me they don't have a culture they identify with. When questioned further, they say they identify with "Canadian culture." If we begin to talk about what exactly they identify with in Canadian culture, the conversation often comes to a halt—unless we break it down to the person's life experiences.

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We can look at the person's value system, spiritual beliefs, artistic enjoyment or practice, and everyday activities, as well as their racial heritage as it pertains to living in today's Canadian culture. One woman I spoke with knew she was of Irish descent, but was unsure what this meant. After learning about, and engaging in, some Celtic cultural practices, she confidently identifies as a member of Irish Canadian culture. Another person named his ethnic heritage, but said he feels much more connected to the sizeable community and culture associated with electronic music.

Connecting people with others from their own cultural background and belief system is essential to promoting and maintaining resiliency (i.e., the capacity to recover quickly from difficulties). It's a way for people to share their strengths and acknowledge their challenges—to have a cultural relationship.

Sometimes, having a cultural relationship means you can sit with someone and feel a sense of peace because you know, without having to explain or express in words, they understand where you've been and what you've experienced.

The importance of cultural connectedness and belonging

In my work as a counsellor and advocate, I've seen the impact of traumatic events on many people. These events have been associated with war; political, sexual, gender, religious and racial oppression; stigma and prejudice of mental health and addictions; physical ability; and socio-economic status. Experiencing trauma often results in mental health concerns such as isolation, loss of self-esteem, substance abuse or dependence, post-traumatic stress disorder (PTSD), anxiety and depression.

I've frequently seen that, once an individual has connected with others who share the same cultural identification, they are more easily able to speak to, and heal from, their trauma. Connection to the larger cultural perspective helps individuals become a part of something they hold dear and encourages a "for the people by the people" perspective.

In trauma situations, we often see a glaring power differential. The person may have been forced by the person or group that perpetrated the trauma to participate in, or witness, acts against their will. Examples include discrimination, mental/physical/spiritual abuses, political oppression and children witnessing violence. A "for the people by the people" perspective decreases the effect of power inequities.

The feeling of belonging and being understood helps heal the impacts of trauma, oftentimes reinforcing resilience. I see this in my work with refugees. When refugees who've already had traumatic encounters arrive in Canada, they experience culture shock. They may lose the hope they had for a sense of peace and a better future. Cultural isolation—a result of language barriers, limited job opportunities, lack of financial resources and not being connected with other people from their country or culture of origin—hinders a sense of belonging.

Reducing cultural isolation is essential to increasing the sense of belonging. Connecting refugees with appropriate resources reduces isolation. Resources include cultural groups they can relate to, community agencies that offer services in their language and that understand their experiences prior to coming to Canada, English-language training and assistance finding employment opportunities.

I've noticed that when the experience of trauma is shared in common with other individuals, this commonality often guides the person to their sense of cultural belonging. For instance, politically oppressed women and men from different countries each have their own traumatic experiences. But individuals often connect more meaningfully with others of a similar oppressive history, rather than others from the same country of origin.

Trauma has impacted Aboriginal people to a devastating degree. Yet, due to the wide-ranging impacts of the trauma among Aboriginal people, there is a common understanding of belonging and identification. The people are readily able to identify and speak to their traumas as a personal and cultural experience—they can sit peacefully with a non-judgmental common understanding. This ability to feel a sense of belonging assists greatly in healing from these traumas.

For many people, cultural practice becomes their way to overcome traumas and increase their resiliency. Every culture has norms, belief systems and values that define its cultural practices. Cultural practice can be related to traditional ceremonies, child-rearing practices and cultural activities such engaging in traditional arts. For many cultures, food is the "tie that binds." Music—with specific instruments and songs—is also incredibly cultural relevant. Aboriginal people in Canada, for example, are reclaiming language and participating in ceremonies such as potlatches, sweat lodges, pow wows and smudging.

Cultural safety in health care

Ideally, we would all be able to sit with a sense of peace with someone from our culture when accessing professional care. This is not realistic for all people all of the time. However, it can definitely be helpful to find a health care provider who has knowledge of the impact of culture in healing. It's even more helpful when professionals provide a sense of cultural safety—that is, create space for culture within dialogue and treatment. It's also beneficial to have culturally relevant resources to refer individuals to in their communities.

Nurturing culturally relevant connection is a powerful way to reduce the impacts of trauma and nourish resilience. v

The Art of Conversation as Medicine?

Jay Peachy

Vancouver's rich diversity of cultures and natural surroundings seems to create inspiration. Beneath the beauty, however, the city rumbles with darkness.

Jay is a multidisciplinary community-engaged artist, a radio and television producer and a protector of the environment. He created Sound Therapy Radio (soundtherapyradio.com) on CJSF 90.1 FM, a national award-winning radio program, and can be found at jpeachygallery.com

Jay hosting Sound Therapy Radio Music/Arts night at Vancouver Fanclub

The Downtown Eastside—a raw and painful showcase of class, post-colonization effects on indigenous peoples, mental health and addiction struggles—is a stark contrast to the shiny office towers rising in the downtown core.

My own mental health crisis manifested itself during my working career in high technology. I was a go-getter, successful, productive and well liked. I was well on the way to the happy-ever-after ending, with a good job, a marriage and a house in North Vancouver. My over-active mind and the insatiable appetite of the corporate world was a dangerous mix, however.

I was officially diagnosed with bipolar disorder in 2004. My manic phases—erratic, irrational, irritable, impulsive—presented many times before that and were highly destructive. I suffered serious financial setbacks and eventually lost my home, my wife and the dreams of the life she and I had worked so hard to build.

During my darkest time I wasted away on a couch in my parents' home. Burdened by guilt, shame and severe depression, I was trapped in a psychological prison of my own making. My mother, originally from the Philippines and a devout Catholic, believed I was in spiritual crisis. And, I believe, she didn't fully trust the mental health system. My mother imposed a regimen of daily prayer, which she felt was care. But I was resistant to what I felt was oppressive Catholicism, and this caused a lot of conflict. After 15 months, when my mother attempted to order an exorcism, friends approached the medical system to get me help.

I spent five weeks in the Sherbrooke Centre at Royal Columbian Hospital, where I discovered art therapy.

Art became my medicine

Dealing with medications, doctors, psychiatrists, the mental health system and disability culture: these were all new worlds to me. But through art I've been able to have dialogue with myself about my lived experience.

During an art therapy session at Sherbrooke, I had an epiphany. In a group art session, we were asked to draw the emotions we were feeling internally on the left side of the paper and our external emotions on the right side. The left side of my paper memorialized my mounting losses, while the right side remained blank. I had no outside.

The act of creating was freeing. All the emotions I'd ignored around the losses in my life seemed to explode and expose themselves through the simplicity of coloured markers on white paper. I gathered more art supplies and paint and began to express more of the emotions I was feeling: the Catholic guilt, the broken relationship with my wife, the loss of time because of my depression. Digging myself out of the emotional hole was a lot of work, but painting created time and space for the needed reflection. I turned my hospital room into an art gallery. I gave my work to others almost as if I was sharing medicine.

From 2006 through 2008 I tried to regain the life I once had. Released on my own recognizance, without a properly working compass and having no money, it seemed my only recourse was to go back into corporate life. Driven by the mania of the business world, I had another roller-coaster ride, only to again end up frustrated and broken, bankrupt and back in the mental health system. It was another long struggle uphill to get back on my feet.

In late 2009, however, an opportunity to work in community radio presented itself. I had a desire to engage in conversations about my mental health as well as to connect with other artists—I think it's in my personality to share and express experiences. Hosting a show about mental health disability became a way for me to raise my voice and to empower myself and others around me.

Sound Therapy

Today's modern world is saturated with media—TV, radio, social media and the Internet. Dialogue on commercialized media is often psychologically violent and provocative. This is how they gain the attention of viewers and advertisers. The pace at which communication takes place can create misunderstanding, and in our fast-paced world, conflict can escalate rapidly.

I don't believe our minds have adapted well to the bombardment of information. It's overwhelming. I feel we need more time and space to process information. To complicate things further, in Vancouver we have a collision of ethnicities, cultures, language and perspectives. It's a beautiful mosaic and a multi-national traffic jam at the same time.

In 2009, a friend and I created Sound Therapy Radio, a one-hour weekly radio show dedicated to engaging conversation about mental health, on CJSF 90.1 FM Burnaby. CJSF is the Simon Fraser University campus community radio station. The show provides a platform for extended dialogue and creative expression around mental health issues. It's intended to share grassroots personal stories; it's about individual spirits and everyday people, not systems, institutions or professionals. We want to have insightful conversations and eliminate stigma. It's peer support radio.

My involvement with Sound Therapy Radio has given me a multi-faceted view around other people's mental health experiences. It's painful hearing others' stories of struggle, whether it's about dealing with PTSD after seeing a car-accident death, or having post-partum depression, or as one young man related, dealing with suicides of multiple friends. It's tempting to try and save people, but I remind myself of my own path and remember that my role is to create a safe space for people to express their stories, and allow the community to understand and share in the compassion.

Sometimes I refer to the radio show as a creative campfire. In Aboriginal cultures, it could be referred to as a talking circle. In essence, it's a way to slow down. Then dialogue can become a powerful tool, creating a safe space for understanding, and in the case of mental health, reducing stigma.

I've more recently been able to expand this conversation into community television in collaboration with community based filmmakers, Sound Therapy Arts TV, which begins airing in April 2014, will bring an arts-based mental health conversation to ShawTV Vancouver.

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My Angel's Brain Broke Down

Kam Kaur*

My dad was raised in a Sikh family in India, the eldest of six children. He came to Canada in 1976, leaving his wife and children (I was three years old) in India until he could get a house here. In India he was in the military and a farmer. In Canada, he worked in a sawmill from 1976 until about 1993. My mom, sister and I came to Canada in 1985, when I was 13.

Kam lives in Metro Vancouver. She's the mother of two and a caregiver to her dad. Kam has a Health Care Worker diploma and works full-time as a medical office assistant. She volunteers at the Sikh Gurudawara (temple) and at her children's school, including the parent advisory council*

*pseudonym

Today, my two children and I live with my father and mother; we moved in a year ago. Prior to that I lived seven years in a marriage and six years as a single mother, though was located close by my parents. My sister, who has two children, lives in the United States.

My dad suffers from schizophrenia disorder, characterized by psychosis symptoms such as hallucinations, delusions and paranoia and by disorganized speech and behaviour. He was diagnosed in 1989, when he was 45. I've known about my dad's illness since 1990, when I was 17.

When I was a teenager Dad said things that didn't make sense to us. He'd say, "There are people outside, black and white, who are going to kill me and my family"—and there'd be no one outside. Though he carried a knife for protection, he wasn't dangerous. He'd call the police; they'd just listen to him, then leave. It was all in his mind.

His brain was playing tricks on him. I felt sorry for him, because we weren't able to convince him that these things weren't real.

Things got really bad in 1989. Dad wasn't able to work much because of severe psychosis, not sleeping and allergies, so knew he needed to get help. Generally, males 'rule' in Sikh culture, so my uncle—my mom's brother-in-law—took my dad to a male Indo-Canadian psychiatrist who spoke Punjabi.

Often Dad wouldn't take his prescribed medication because he didn't think there was anything wrong with him. So my mom would put the liquid meds in his food. At times he'd think she was poisoning him, so he'd make his own meals and wouldn't take food from anyone else. When he took his medications regularly, his symptoms were well controlled.

From 1989 to 1993 Dad worked on and off. But then, on the recommendation of his psychiatrist, he went on disability income. This was very little income to support the family, so my mom started to work outside the home, her family helped financially, and my sister and I worked part-time while going to school.

Dad was stable from 1994 to 2008. In 2009, however, his hand started shaking severely, a side effect of the medication he'd been on all those years. He was switched to a newer antipsychotic, and, basically, everything fell apart.

Also in 2009 Dad went into a catatonic state where he could hear everything but couldn't move his body or open his eyes. As a result he ended up in the psych unit at Vancouver General Hospital for four weeks. This was hard on me, a single mom with kids, working full-time and visiting him at the hospital every day on my lunch break. Sometimes Dad would beg me to take him home because he thought the nurses were harming him. He'd call me 20 times a day to check that I wasn't being harmed by strangers.

When he got home, mom and I had to retrain him to do simple things like pouring his cereal from the box into a bowl and to do simple chores, to help him return to daily functioning. We encouraged him not to sleep all day, to get out of the house and to walk a bit.

It took about six months for his new medications to start working. Still, in the past four years, Dad has had periods of believing people are spraying gas and he constantly checks around the house. He coughs because of the 'gas.' He also believes there are people in the basement talking about him and reporting everything to the underground world. He runs out of the house to get help and wants to go stay in the hospital for his safety.

Since 2009, every time the season changes, so does his mood. Sometimes the change is minor and sometimes it's major. When he's not well, he's very anxious, doesn't sleep much, keeps everyone awake, and worries a lot about me and Mom and the kids.

Burdens and blessings

It can be hard. He has been admitted to hospital four times in the past five years. In the summers of 2010, 2011 and 2012, I had to cancel vacations with my kids because Dad wasn't well. This year, however, we went on vacation and had a lovely time; my mom was able to manage him.

Last year Dad went through a period of being afraid to drive, so I had to do all my parents' chores without much help. Plus, Dad requires follow-up visits to his psychiatrist and family doctor, as he gets injections every three weeks. Thankfully he's driving again. (It's a funny thing: my dad now keeps track of when he needs his medication injections and never misses. I think he's finally realized he has mental illness, though he doesn't express this to us.)

I found it hard that we never talked about my dad's illness outside of our family, which includes my mom's siblings and their spouses. Most of my dad's family were in India until recently. And I wish there'd been more community support for Sikh families and a support group to go to back in the 1980s and '90s.

Now there's much more awareness and courses one can take. In 2010 I attended a family support group at

I found it hard that we never talked about my dad's illness outside of our family, which includes my mom's siblings and their spouses. Most of my dad's family were in India until recently. And I wish there'd been more community support for Sikh families and a support group to go to back in the 1980s and '90s.

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Raven Song Community Health Centre in Vancouver. It's very helpful to hear about other families' daily struggles and how they cope. I could relate to other people's pain at seeing their loved one suffer, and I learned how to support my dad better.

I also took a nine-week course there called Strengthening Families, which helped me understand more about mental illness. I'm now more open to talking to other people about my dad's illness. There's nothing to be ashamed or embarrassed about.

Dad is very lucky. He's been blessed with good medical help and strong family support. We—my mom, me, my sister and my mom's family—have always stood by my dad and helped him to do his daily exercise, prayers and whatever else was needed.

In Sikh culture the kids are supposed to look after their parents; it's not common to put them in a care home. But today, in Canadian Sikh culture, people are looking at their individual situations. Ideally, I want to take care of my parents at home. But if my dad's condition worsens and mom and/or I can't cope, we'll have a family meeting to decide what's best for Dad and for our family.

Right now the situation is fine; we're able to look after him. We stay positive and take things day by day, one step at a time. And since I've moved in with my parents, I'm there for both of them. My dad is going to be 70 next year, and my mom is 65.

Dad is very independent—he cooks, does household chores, helps Mom with yard work and drives my mom since she doesn't drive. Until recently, he played many sports. Now he meditates daily, volunteers at the Sikh temple and takes part in a social group at the local seniors centre. My kids go bike riding with my dad, and we all go for walks with him. My cousins drive Dad to his doctor's appointments, if needed. And this year I've signed my dad up to take the HandyDART if I'm busy.

I believe everyone in one's life is a blessing from God/higher power/the universe. I've learned so much from my dad. When he's well, he's such a good, spiritual, positive and active father. He sacrificed a lot to give his family a good life in Canada. He had two daughters, but never once said "if only I had a son." (In Sikh families the son takes over the family home and name; girls are looked down upon as a burden, even killed or aborted for not being a boy.)

When Dad became ill, my mom had to take over responsibilities like managing the money, which started a shift away from the traditional roles. I'm very thankful that my parents never turned their back on my sister and me, and that we've always been encouraged to make our own decisions.

Truly, through the burden of my dad's illness, I've learned so much about life. I call Dad "my angel." v

CONTINUED FROM PAGE 11

Mental health issues will be explored through a myriad of formats and arts disciplines, such as interviews, performances, stories, films, stand-up comedy and festival coverage.

We need to create even more opportunities for these spaces of meaningful, compassionate and courageous discussion—such conversation opens up possibilities and can be a gateway to healing.

Creating my own safe 'water' world

I don't regret this up-and-down journey through life. The metaphor of a fish comes to mind: I've swum through turbulent and somewhat toxic corporate waters, to the system of support ladders and dams created by the social safety net. I've swum alongside other broken spirits who, like many people in the Downtown Eastside of Vancouver, are focused on everyday survival.

Through discovering my creative being, I'm now able to take all these experiences and create the world that works for me. I swim in solidarity with the Indigenous people who have been caretakers of the land and have a nature-based spirituality. And I can imagine and create a free, positive and safe water that I desire to live in. v

Pretty Girls

Jolene Friesen

"Again and again, the same situation for so many years
Tethered to a ringing telephone in a room full of mirrors
A pretty girl in your bathroom, checking out her sex appeal
I asked myself when you said you loved me
'Do you think this can be real?'" *

Jolene resides in Langley with her husband Bob and dog Rapha. She enjoys walking her dog and writing about her experiences. Jolene and her husband lead a small informal group for couples that focuses on attachment needs within intimate relationships

*From Joni Mitchell's song "The Same Situation," on her 1973 album Court and Spark.

I didn't decide to stop eating one day when I was 11 years old so I could look like the thin model in a magazine picture. That came later. But I was 11 when I first lost my appetite—a sign that a storm was raging in the ocean of my soul. It was a direct response to the sexual abuse at the hands of a relative, which started just prior to my 11th birthday.

When I was 12, near the end of a month-long tour of Europe with a youth choir, the conductor noticed I'd lost a lot of weight. She told me, "You look anorexic; you better eat or I'll tell your parents." I didn't know what "anorexic" was, but from her tone it sounded like a character flaw; a sin. I didn't want to get into trouble so I filled my plate with cauliflower, only to throw it out when she wasn't looking.

I didn't get into trouble when I got home, so the conductor mustn't have told my parents about my not eating. But the sexual abuse resumed. Everything returned to 'normal.'

I grew up in a religious home and attended a private religious school. My preoccupation with morality and spirituality heightened when I was 12. This awareness of moral goodness versus evil was honed to a desperately nasty point when I began to blame myself for

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> This awareness of moral goodness versus evil was honed to a desperately nasty point when I began to blame myself for the abuse.

the abuse. I wrote in my journal, "How can God ever forgive me for making a man be an adulterer?"

I hesitated to include this segment of my story, because I recognize that people have many different opinions about religion and God. I love God, and I don't want to add fuel to anyone's negative fire about something as precious to me as my relationship with the Creator. Now, as an adult, I know it wasn't religion that caused me to think of myself as an evil sinner; rather, it was that so much occurring in my life went unnoticed.

The abuse, my weight fluctuations and, apparently, my thought processes all went pretty much unchecked and unattended by my parents, teachers and the youth leaders at my church. Why was I repeatedly excused from the dinner table when all I'd done is push food around my plate? Why did no one notice my switch from wearing trendy clothes to wearing many layers, often choosing men's clothing, to hide my size and frame?

Mentally, I struggled with a strange triangle of thoughts. The first angle was my desire to be liked, which butted heads with the fear that I was different from my peers because of the abuse. I wanted to be liked, but I was afraid of being liked too much. My changing body and the continuing abuse both pounded the message home that I lacked control over my body and my life. I feared that my blooming womanhood and sexuality would attract yet more unwanted physical attention.

The second angle was my recognition that people treated certain types of girls differently than others. By the time I started junior high school at age 13, I noticed how the boys treated the girls. The boys paid a lot of attention to girls who wore popular clothing brands, had their hair permed, sported blue eyeliner and tight white Levis with leather boots, and smelled of Polo or Obsession perfumes. These girls usually came from homes with money. Other girls clustered around them, vying for position of 'best friend,' like crows fighting over the carcass of a dead animal.

Adults—the teachers, the church leaders, the parents—also shined their favour on these girls, whose parents often held positions of power or prestige in the community.

I was in a clique of six girls, one of whom dressed and smelled 'just right.' Another of the girls was big-boned and heavy-set, and constantly on some strange diet or another at the behest of her parents. Even among us six, the 'attractiveness' inequity was apparent. While five of us shared wearing shirts and sweaters, I could see the pain in our larger friend's eyes at being excluded from this rite of friendship. When we held swimming parties, our friend would be sitting to the side, or simply absent.

Also at 13, my best friend and I began buying Cosmopolitan magazine, and would pour over the pictures. In the '80s, the popular clothing brands were Esprit, Ralph Lauren and Calvin Klein (all still flourishing today). Calvin Klein had a series of advertisements about which people often commented that the models "looked like crack addicts." To me, they did look incredibly skinny and somewhat sexually 'used'—and yet . . .

The third angle was the growing belief that if I could be like those models, I'd be liked, wanted and no longer afraid of my own femininity and sexuality. I think it was the confidence portrayed by the women in magazines and on television that appealed to me. Their ability to stand brazenly in front of a camera, not caring that so much of their skin was exposed, was a harsh juxtaposition to what I felt about my body when it was naked. I couldn't change clothes in front of a mirror; my disgust at my femininity was overwhelming. When undressed by my abuser, an event always marked with physical struggle between him and me, the fear and shame reached pinnacle heights.

By the time I was 13 I'd moved the scale in my parents' bathroom to my bathroom. I sometimes weighed myself as often as 30 times a day. When the number on the scale went up, terror made my appetite disappear. Then, down the numbers would plunge.

At 14, I told my parents about the abuse, hoping that would stop it. Unfortunately, nothing was done. My parents were unskilled in dealing with trauma, as neither sexual abuse nor childhood trauma were understood in

the early 1980s as they are now. Additionally, the abuser was both a relative and held a position of power in church. These factors, I'm certain, hindered my parents from taking action.

The abuse continued, as did my weight fluctuations. However, by this time I'd added purging to the mix. On occasions when I did eat, I'd make myself vomit. And on top of that—just to make sure everything was out of my system—I took laxatives, often more than 500 pills a day.

In my journals, I recorded everything I ate, the number of times I vomited, and the number of laxatives I took each day. I also wrote extensively about how I hated myself. Certain statements were repeated and became slogans. "I loathe, detest, despise and abhor myself." "I should be taken to the curb with the trash." "Someone should take me behind the barn and put me out of my misery." "I am fat and ugly." Regardless of my weight, these statements were written with vengeance and spite.

My emotions and the events of my life were uncontrollable. Turning the energy of anger and fear on my body was a storm I could weather more easily.

Weathering ups and downs today

The yoyo of weight gain and loss continues to this day. I'm just shy of 5 feet 11 inches, and my weight has gone up and down between a healthy 155 pounds and less than 80 pounds. Despite these incredible changes in weight, I wasn't diagnosed with an eating disorder until age 39. My husband's family intervened when I had a particularly rapid loss of weight, losing 49 pounds in as many days.

Since being diagnosed in 2010, I've been medically stabilized through two stays at St. Paul's Hospital in Vancouver, totalling two months. At St. Paul's I was diagnosed with anorexia nervosa, major depressive disorder, general anxiety disorder and post-traumatic stress disorder (PTSD). This has been followed up with care through a local mental health office, where I've been seeing a psychiatrist and a social worker who specializes in eating disorders. In addition, I've pursued extensive personal therapy with counsellors who specialize in PTSD, and have attended various therapy groups offered by Langley Hospital Group Therapy Services.

I often ask myself if I'd still be at war with my body had circumstances been different. Would the eating disorder have developed if the abuse hadn't happened, or if I hadn't read Cosmopolitan? But I can't identify any one cause. Abuse, moral development, social awkwardness, parental inattention and pictures of skinny girls were just some of the ingredients.

Anorexia is the debris following the perfect storm; it's the flotsam and jetsam of childhood trauma not attended to by my caregivers. Waves still overwhelm me at times, and I can only call for help. But there are other times when the sea is calmer—or perhaps I'm a stronger swimmer. In those times, I head for shore. v

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Addressing Weight Bias and Stigma in Health Care

Kiera Ishmael, MPH, and Kimberley Korf-Uzan, MPH

In our society, it's considered important to be thin and fit. Have you ever noticed that people worry and talk a lot about their weight and appearance? Have you heard people comment on others' bodies, or even their own, in a negative way?

Kiera is a Project Manager with the BC Mental Health and Substance Use Services (BCMHSUS) Health Literacy Team. Her work involves leading health literacy initiatives that focus on eating disorders. Kiera is passionate about prevention and is co-leading the creation of BalancedView—an online resource for addressing weight bias and stigma in the health care setting

Kimberley is also a Project Manager with the BCMHSUS Health Literacy Team. She is involved in a number of initiatives related to healthy weights, body image and eating disorders. Kimberley is co-leading the creation of BalancedView

In a society that values thinness, negative attitudes toward larger bodies can be common. Weight bias and stigma exists in employment, education and health care.

What is weight bias and stigma?

Weight bias refers to negative attitudes, beliefs, assumptions and judgments toward people who have larger body sizes.[1,2] These attitudes can often lead to negative stereotypes, which cause people to wrongly assume that people who are heavier have a number of negative qualities. Examples include the false belief that larger people are physically unattractive, incompetent, lazy, unmotivated, lacking self-discipline and sloppy.[3,4]

A person may experience stigma when they have a characteristic (such as being heavy) that is not valued by the society they live in.[5] When someone is stigmatized because of their weight, it means that the way others react to them or treat them can make them feel like a less important or less valuable member of society.[6]

What are the impacts of weight bias and stigma?

Research has shown that weight bias has an impact on both physical and mental health, regardless of a person's weight. This means that weight bias itself can cause harm to health. Examples of these harms include poor body image, low self-esteem, low self-confidence, loneliness, depression, anxiety, disordered eating, stress and avoidance of physical activity.[3] Patients who experience weight bias in health care settings may avoid or delay seeking health care. This can lead to health risks, including failure to diagnose and treat illnesses—which can be life-threatening. Research has shown that individuals who have a larger body size are less likely to be screened

regularly for things like breast, cervical or colorectal cancer.

Reasons patients may avoid health care include feeling a lack of respect while being treated, having negative interactions with health care providers, being embarrassed about being weighed and receiving advice about losing weight, or encountering medical equipment that is too small for larger bodies.[3]

The harms to health that can be caused by weight bias and stigma make it an important issue to address.[7] BC Mental Health and Substance Use Services (BCMHSUS) is an example of one organization which is working towards reducing weight bias and stigma in health care settings in BC.

What is BalancedView?

BalancedView is an online, interactive module being developed by BCMHSUS, an agency of the Provincial Health Services Authority. The resource is being developed in collaboration with experts and health care providers from around the province. BalancedView is expected to be available in the fall of 2014.

The goal of this resource is to decrease weight bias and stigma among health care professionals in British Columbia. Examples of health care providers include doctors, nurses, psychologists and psychiatrists, social workers and physiotherapists, among others.

BalancedView will educate health care providers about the meaning of weight bias and stigma, how it happens in health care, and the negative effect it can have on a patient's health and overall well-being. For example, patients have described two ways that weight discrimination can happen in the health care system. The first occurs when a health professional focuses on a patient's weight, even though the patient is looking for help for another issue. The second occurs when a health professional avoids talking about weight with their patient because they don't feel well-prepared to address weight-related issues. Each situation can lead to frustration for both patients and health care providers.

The online module will also introduce health care providers to practical tips and tools for making changes in their practice. For example, health care providers can use the following strategies to guide their conversations with patients:

- initiate any conversation about weight respectfully
- listen to and try to understand the context of people's lives
- work collaboratively with patients to meet their health goals
- understand food as more than "fuel"
- understand a person's beliefs about their own weight

A main focus of the resource will be on helping health care providers to promote the overall health and well-being of their patients, rather than focusing on a person's weight as the only measure of their health. For example, health care providers can encourage healthy behaviours, such as eating a balanced diet and enjoying physical activity, rather than promoting weight loss as a way to improve health.

BalancedView will also contain information, videos, quizzes and activities that will encourage health care providers to explore their own thoughts, feelings and attitudes about weight and the relationship between weight and health. The goal of this education and self-reflection is to allow health care providers to build better relationships with patients who are experiencing weight-related issues. In some cases, they may also make changes to their practice, which will result in better health outcomes for their patients.

BalancedView is just one piece of a bigger movement toward promoting a focus on health rather than weight. Changing social norms related to body weight is a big task. But people in BC are being encouraged to challenge some of their attitudes and assumptions about weight, and are learning to appreciate the fact that healthy bodies can come in different shapes and sizes. By shifting the focus from weight to well-being, together we can promote better overall health for all British Columbians.

For more information about BalancedView, contact Kiera Ishmael at 604-875-2866 or kishmael@cw.bc.ca

Culture, Secure Attachment and Trust

PROTECTIVE FACTORS THAT SUPPORT MENTAL WELL-BEING

Lanny Kipling, RPN

Connecting the Dots (CTD) is a four-year community mobilization pilot project that aims to promote mental health for urban Aboriginal families and youth. CTD follows the Communities That Care model, which uses a proven, community-change process for reducing youth violence, alcohol and tobacco use, and delinquency (see www.communitiesthatcare.net).

Lanny has two beautiful children, Colton and Tara. He's a registered psychiatric nurse and coordinates the Connecting the Dots project at the Quesnel Tillicum Society. Lanny also chairs the Quesnel Mental Health Advisory Committee and sits on parenting and child service boards. He loves the outdoors and helping people*

*Connecting the Dots is funded in 3 BC communities by the Public Health Agency of Canada. Provincial coordination is led by CMHA BC Division and the BC Association of Aboriginal Friendship Centres. For more information, visit www.cmha.bc.ca/connectingthedots

This approach has the community identify its main risk and protective factors, then follow up with evidence-based practices to strengthen the protective factors and reduce risk factors. These interventions are then evaluated, either in the form of written surveys, questionnaires or focus groups, including questions specific to mental health promotion. CTD has also contracted with the University of Northern British Columbia to be evaluated throughout the project by an assistant professor, who is also the Aboriginal Education coordinator. Practices will be adjusted, if necessary, to ensure they are effective.

In our community, Quesnel and the surrounding area, representatives from non-profit health service organizations, the school district, Ministry of Children and Family Development, Northern Health, University of Northern BC, the local college, non-profit Aboriginal organizations, local First Nation bands including the Elders, and youth within the school district have come together. The main protective factors identified by this group are attachment, or strong connections between children, parents and Elders; healthy parenting; and culture. The main risk factor identified was a lack of trust between Aboriginal people and service providers.

To address these risk and protective factors, we are implementing family/culture camps, parenting/traditional teaching modules and trust building circles. These interventions were identified by the project's community board and key leaders working group, consisting of all those listed above except the youth. This group's role is to provide insight and guidance for each CTD step, to support project sustainability by opening doors to funding sources, and to ensure that interventions and processes are aligned with the values and rights of the Aboriginal people.

It has been the consistent commitment from, and wisdom of, our local Elders through the Elders Guiding Circle,

Horseback riding was a huge hit for youth at the culture camp.

Health benefits are more probable when people marinate in a comfortable environment... surrounded by others who genuinely care, accept and respect who they are.

however, that has fine-tuned these interventions. The Elders accurately reflect the needs of their people and recommend appropriate tribal best practices to support mental health and bring balance and harmony back into people's lives.

The Elders have stressed the importance of learning one's culture, including traditional ceremonies, language and healing practices. Reclaiming culture into the lives of the children, youth, parents and Elders has health benefits on the physical, mental, emotional and spiritual levels. It builds individual strength, a sense of belonging with self and community, resilience and pride. Culture not only supports one's values and beliefs, but more importantly, one's identity.

Caring interventions

In August 2013 we held our first family/culture camp called The Future Is Now—Break the Cycle Gathering. Elders supported the following teachings to be part of the first camp: rites of passage, medicinal plants and their healing properties, the traditional game of lahal, traditional drumming and singing, a healing circle led by a traditional teacher, storytelling by the fire, horseback riding, fishing, a presentation and discussion on healthy parenting, a motivational speaker on overcoming life's challenges, swimming, a sweat lodge for the adults/Elders, and morning prayers, to name a few.

People attending the camp, from infant to Elder, were not only reclaiming their culture, but connecting with the people they love and care about. Being accepted and bonding with family, Elders and friends creates a base of secure attachment, which is a significant protective factor supporting mental health. Health benefits are more probable when people marinate in a comfortable environment that supports their worldviews, surrounded by others who genuinely care, accept and respect who they are. Their self-esteem is more likely to increase, and they tend to make healthier life choices. They are less likely to misuse substances such as drugs and alcohol, less likely to be violent and more apt to contribute to society in a positive manner.[1]

Here are some responses from people who attended the family camp when asked what they enjoyed most about the camp: "People getting together." "I enjoyed the children being happy." "The sweat was great; we need more of that—happy children, happy people." "Gathering of other people, children and all nations." "Relaxing and quiet being in nature; so nice, no TV and video games." "Staying sober, walking trails and fishing." "Being together and bonding with family." "Being together with family and friends like we did a long time ago."

Elders teaching rites of passage to the female youth.

Family/culture camps, however, only happen once or twice a year, so are only one piece of the puzzle for our community's well-being. In order to address mental health effectively, it's important to have consistent, ongoing support around parenting, attachment, trust and culture.

To address our risk of a lack of trust between Aboriginal people and service providers, CTD has held two trust building circles (TBC) and will continue holding them four times a year. The TBC participants are a healthy mix of Aboriginal people and service providers (e.g., First Nations support workers, school counsellors, support

Family and friends fishing off of the Euchiniko River bridge.

Youth learning how to play the traditional game of lahal.

workers from MCFD, mental health and addiction counsellors) who are working together to help Aboriginal people feel safer using services to support their mental health. Trust is a key ingredient in the healing process.

Our last intervention, intended to provide consistent support addressing our main protective factors of parenting, attachment and culture, just began in February 2014. It's a monthly half-day module where the Aboriginal community comes together to learn parenting skills and tools, then a traditional teaching. The culture's worldviews, values and beliefs are built on the seven teachings of truth, wisdom, love, honesty, respect, courage and humility, which have been instilled in the culture for thousands of years. They provide balance and harmony within the community and families, and help build a sense of empowerment within the community and individuals.

While Aboriginal people have been encouraged over the years to participate in many programs and services to support their health, it's exciting to experience that, with the insight and guidance from the Elders, 'dots are being connected.' Elders within the four local First Nation bands in Quesnel are communicating, sharing stories and building relationships with Elders and parents they hadn't previously had relationships with. Parents are encouraging their children more to attend and participate in cultural activities and events. Elders are becoming more comfortable sharing their truth and concerns about the needs of their people with local service providers.

Genuine connections are being made. This has created a positive shift in mental well-being for the people in our community today and for future generations. v

MDABC South Asia Program

Tammy Iny

The Mood Disorders Association of British Columbia (MDABC) provides culturally relevant information, support and education about mood disorders and other mental illnesses to the South Asian community in Surrey and Delta.

The cities of Surrey and Delta have combined populations of 568,114 people;[1] roughly 26% of the residents (147,709) are South Asian.[2] Given that we know the incidence of mental illness is 20% of all Canadians,[3] we estimate there are almost 30,000 South Asians needing services and resources in Surrey/Delta. Toward that end, we provide information sessions, education groups, radio and television presence and online resources in the Punjabi, Hindi and Urdu languages.

MCABC has offered depression and anxiety education groups for the South Asian community since 2006. The groups are open, which means they are free of charge. There is no registration or referral required, participants can attend as many sessions as they like, and they can begin attending at any point in time.

The groups are facilitated, in Punjabi, by psychologist Dr. Rajpal Singh, and they meet at the Progressive Intercultural Community Services Society in Surrey. There have been separate groups for South Asian women and men, as is culturally relevant and historically correct—South Asian women and men have been separated in certain circumstances for many generations. When it comes to topics like illnesses and sexuality, South Asian women and men choose to deal with these concerns within their gender group.

For the purposes of the MDABC South Asian education groups, both groups have been professionally led by male facilitators. This is because, in the South Asian community, education is respected. If there was a South Asian woman psychologist with comparable education available, she would be welcome to facilitate either a men's or women's group. This issue is about South Asian people's respect of professionalism, not disrespect of gender.

Since 2011 only the women's group has been offered. This change was due to loss of a meeting room, and attendance clearly indicated that Punjabi women were in need of the groups more than the men. However, Dr. Singh continues to seek meeting space for the men's group.

In terms of content for the education group, Dr. Singh uses a combination of group cognitive-behavioural therapy

Tammy, at 33 years old, has been treated for depression, anxiety and, most recently, bipolar disorder. She volunteers at the Mood Disorders Association of British Columbia, where she is an office greeter. Tammy lives in Vancouver

and interpersonal therapy techniques. The Punjabi groups differ from other MDABC support groups in that there is a formal educational component rather than just peer support. This style of group reaches members of the community who because of stigma might not attend a peer-led support group. Dr. Singh finds that the South Asian community is more trusting and comfortable attending these groups because he is a mental health professional.

In our efforts to engage the South Asian community, Dr. Singh thought that public forums on mood disorders were needed. The stigma in the South Asian community is such that any discussion of mental illness needed to be brought to the community by professionals so the information would be trusted by the community. The public forums drew potential group members. Since the inception of the program, there has been no trouble filling spots in these groups, which have had an average of over 20 participants per session.

As well as providing education events about mood disorders, we also have TV and radio programming aimed at the South Asian community. All these outreach methods have been made possible with funding from BC Partners for Mental Health and Addictions Information with some generous donations of air time by media outlets, as well as assistance from other concerned professionals.

The first education event in 2006 was held in Surrey and was advertised through word of mouth and the MDABC website. It was presented in the Punjabi language. This event drew 74 attendees. In 2010 the attendance at a similar education event increased to 280 people from the South Asian community. This jump in attendance confirmed the need for mental health service in this community.

In terms of other members of the South Asian community, the MDABC hired a coordinator to reach out to Muslim women. Again, the method of connection has been to provide education events, then create groups. The MDABC has held education events in the Urdu-speaking community, and provides mental health information sheets in Urdu on our website. We are still in the education stage of our outreach; education groups will follow in the future.

A variety of strategies have been adopted for effectively reaching and disseminating information to the South Asian community. We have created mental health information packages containing mental health facts and resources; these are regularly dropped off at local businesses. We collaborate with Surrey family doctors to present mental health information to their South Asian patients. These family doctors also participate as presenters in the education groups and as guest presenters on our television appearances. Drs. Ayesha Afzal and Malek Moosa, two female Muslim family doctors, also contribute to the cause.

MDABC has regularly had information tables and booths at a variety of venues, including the Burnaby Mosque Health Fair, the IQRA Islamic School in Surrey and a UBC Muslim Youth Association event attended by 300 students and their families. We have also presented at the Canadian Society of Fiji Muslims family night event attended by 200 people (included a talk on depression by Dr. Singh) and at the Pakistan Canadian Cultural Association's women-only Eid celebration attended by about 500 women.

In May 2013, Dr. Singh started a weekly appearance on JOY TV's Harpreet Singh Show, which focuses on the positive contributions of Indo-Canadians to Canadian society. Dr. Singh discusses aspects of mental health, in the Punjabi language. Videos of these segments can be viewed on the MDABC website (www.mdabc.net/dr-rajpal-singh-harpreet-singh-show). After a show is aired, Dr. Singh takes phone calls from viewers every Saturday between 3 and 5 p.m., answering questions in the Punjabi, Hindi, Urdu and English languages.

In addition to TV, Dr. Singh also speaks to the community through his one-hour monthly interactive radio show on RED 93.1 FM, a South Asian Broadcasting Corporation station. The program is called Roshni, presented in the Punjabi language.

Because mental health treatment translates differently across communities, it is vital that resources be made available to people in their respective languages and suited to cultural traditions. The MDABC has worked hard over the past few years to develop capacity within the South Asian community to help and support its members who suffer from mood and other mental disorders. v

The Influence of Culture on Campus Substance Use

EXPLORING WHAT COULD BE

Catriona Remocker, MPH

Today's universities and colleges have a reputation as settings where substance use is sometimes problematic. Post-secondary campuses struggle with students using alcohol and other substances in risky ways and causing harm to both themselves and others.

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Catriona is Project Coordinator of the Changing the Culture of Substance Use project. She is a Research Associate with the Centre for Addictions Research of BC, in the Knowledge Exchange division

* The Changing the Culture of Substance Use project is part of the BC Healthy Minds/Healthy Campuses initiative. Funding is provided by the BC Ministry of Health and from BC Mental Health and Addiction Services as part of their support for BC Partners for Mental Health and Substance Use Information. It's a partnership project between the Canadian Mental Health Association, BC Division and the Centre for Addictions Research of BC.

Changing the Culture of Substance Use (CCSU),* a two-year project that started in September 2012, takes a new approach to addressing these issues. Rather than focusing on how individual students use substances, our project asks the question, "How is the culture on our campuses affecting the way young people use substances?" and "What can institutions do to promote a culture that supports the development of healthier relationships with substances?"

Often, culture is used to refer to the rituals, beliefs or customs of particular groups of people. But culture can be thought of more broadly than this. According to Australian biologist Richard Eckersley, culture can simply be thought of as this "fuzzy, complex, dynamic and multi-faceted thing" that is "variably distributed, locally influenced and intimately connected to history, politics, economics and other social factors."[1]

Why is this view of culture significant and how does it influence our behaviour? The Centre for Intercultural Learning offers, "Culture rules virtually every aspect of our life… [it] is vital because it enables its members to function with one another without the need to negotiate meaning at every moment."[2] And cross-cultural psychologist Gert Hofstede says that "culture is the software of the mind."[3]

Essentially, this means that culture influences our behaviour without us generally being aware of it. While targeting cultural change may not be the only way we can influence human

behaviour, it's one potential way to have a broad impact on a lot of people.

So what does this mean for our post-secondary campuses? Well, imagine that you're starting your first year at university. You'll have expectations about university life—about frosh week (first-year orientation week), study habits, residence life—along with ideas about the ways you should act if you want to make friends.

These expectations will have developed over time and will be rooted in history, both recent and ancient. And they may be impacted by the current social, economic and political environment, and the media. As an example, research actually showed that the debut of the film Animal House in 1978 directly corresponded with increases in risky drinking behaviours among college students. Even though the film is now over 30 years old, its influence on behaviour still persists because it has infiltrated our cultural norms and expectations around post-secondary student drinking behaviours.[4]

In addition to these societal influences, the culture of the specific university you go to will make a difference to your experience. Health behaviours of students, including alcohol and substance use behaviours, vary dramatically from institution to institution.[5] For instance, some campuses have a 'party reputation' that is well-known to incoming students, whereas others may have less of a 'known' social scene. Students may simply know these other institutions to have high academic standards or excellent athletics programs.

Campus reputations can impact which students choose to attend a particular institution (self-selection effects). And, once students are on campus, it may affect their choices about when and how much to party (peer pressure effects). An additional complication is that sometimes, student beliefs about how much other students are using substances is actually an overestimation of the reality (social norms effects), yet can encourage students to use more than they are comfortable with.

Once on campus, students may find themselves attracted to particular groups (e.g., Greek life [sororities and fraternities] or student athletics) that will offer subcultures they believe will help meet their social needs and goals. The impact of these subcultures can be mixed. Students involved in athletics, for instance, will gain social and health benefits from involvement. However, they also can be at increased risk for excessive alcohol consumption and its associated negative consequences.[6]

Invariably, the culture and subcultures of the institution will influence your first-year experience, the behavioural patterns and practices you adopt (both related and unrelated to substance use), and the choices you make in the future.

Becoming conscious consumers of culture

Addressing the influence of culture on substance use is no small undertaking and involves many significant challenges. Culture is abstract, multi-faceted, complex, dynamic and yet resistant to change. Things get even more complex when we ask, "If not this culture, then which culture?"

We don't consider ourselves experts in answering these questions or prescribing any specific course of action for campuses. The goal of our project is not to find or assign the 'right' culture. Instead, we aim to help campuses increase their understanding of culture as a key influence on behaviour and to encourage members of the campus to become educated critics of culture.

With increased awareness of the influence of culture, we can begin to reprogram some of the "software of the mind." As educated critics of

> Rather than focusing on how individual students use substances, our project asks the question, "How is the culture on our campuses affecting the way young people use substances?"

culture, campus members can reflect on the positive and negative potential influences of culture on themselves and others. So, instead of being unconsciously driven by culture, they can actually make choices based on personal values and ideals and as informed consumers of culture.

Working toward healthier campus cultures

To bring our project to life, we are creating a community of practice. This is a sustainable, committed community of interested individuals (students, faculty, staff, etc.) from across BC who are willing to learn and work on these issues.

As we work with our community members, we ask difficult questions, provide support and consultation, and assist in the process of developing action plans for individual campuses. For instance, we would ask institutions with a 'party reputation' to examine how they could mitigate this influence, and an action plan might be to offer alcohol-free residence accommodations to students who don't want their studies disrupted by on-campus parties.

Involved campuses have moved forward in this project in a variety of ways. For instance, Selkirk College has made great strides in generating community dialogue and engagement, focusing heavily on including students in their process. One of these efforts has been the development of the Dinner Party program, which gives students the opportunity to prepare a meal together, while examining their relationships with substances through focused discussion.

Another example comes from the University of Victoria, which has developed a comprehensive strategy that integrates health, residence and counselling services, to create a culture of moderation on campus. UVic has used data gathered from the National College Health Assessment (www.acha-ncha.org) survey to create 'Data Dialogues.' These have been used to approach interested groups to discuss the culture of substance use on campus and how they might address change.

Many campuses initially struggled in this project to make visible changes, and some came up against political and organizational barriers in their institution. However, these campuses have persevered and many are now making exciting progress toward attaining their culture-change goals.

Additionally, through the project's collaborative learning process, campuses have been helping each other to take strides toward breaking down divisions between various campus members and groups and encouraging dialogue and co-operation among campus members.

Whatever the level of progress on each campus, we focus on what can be accomplished in the short term, as well as how to prepare for sustainable changes in the future. The project is scheduled to complete in August 2014; however, we plan to integrate the community we've built into a larger community of practice in the province—the Healthy Minds/Healthy Campuses initiative (www.healthycampuses.ca). We hope our campuses, supported by this community, will continue making strides toward their goals.

We also ensure that processes and sub-projects in our community are documented and become resources that benefit and inform other campuses. As such, we are building a website for the public, where finished resources will be housed. There will also be a communication platform where member campuses can continue learning, working and creating further resources together.

Moving toward a cultural legacy

We believe that raising consciousness about the influence of culture on substance use, shifting the language around substance use, and encouraging open dialogue about our relationships with substances will be valuable legacies of this project. Shifting a culture is not easy, but it might be the most important thing we can do toward creating positive change for today's young people and the coming generations. V

Culturally Competent Care for Men

Duncan Shields, MA, RCC

Mental health professionals are becoming increasingly aware that a person's culture shapes their identity, values, attitudes and beliefs in key ways. These cultural differences can also shape how people experience mental health challenges, what they believe about the meaning of the challenges they face, and what they feel would be helpful for them as treatment or healing.

Duncan is a Counsellor in private practice, and president of the BC Association of Clinical Counsellors. He is the Canadian Wounded Warriors Doctoral Scholar and is currently conducting biopsychosocial research at the University of British Columbia in the area of war trauma and masculine socialization

While mental health counsellors and clients may not share the same cultural background, it's important that counsellors respect the cultural background of the clients they work with, and be open to discussing how care can best "fit" the client. Counsellors need to be "culturally competent;" that is, speak and work with their clients in ways that make sense to the client and that don't alienate them.

Feminist theorists have suggested that—in addition to what we normally think of as cultures, such as South East Asian or White Anglo-Saxon and so on—female gender (femininity) can also be understood as a kind of culture. This culture shapes societies' expectations for females and can affect attitudes, opportunities, power in relationships and identity. For decades, university counsellor training programs have prepared mental health professionals to consider these kinds of impacts when working with female clients.

The mental health profession, however, has been slow to consider what effect male gender (masculinity) has on attitudes, opportunities and power in relationships when men experience mental health challenges.

It's important to be clear about the differences between the terms, gender and sex, two central parts of our identity that are frequently confused. Sex describes the biological makeup of the male and female body, while gender refers to a series of social

Traditional men have not been served well by our mental health system. In part, this is because we've been slow to recognize masculinity as "culture" and to consider that culture respectfully.

roles and behaviours we begin to learn as children and are exposed to throughout our lives (e.g., masculinity or femininity).

While some functions, particularly reproductive, are determined by biology, all cultures have behaviour norms for males and females. These behaviour norms extend into every area of work, family life and social convention.[1] Each culture or social group may have slightly different expectations for the masculine and feminine role, but they are usually significant parts of how individuals in that social group understand themselves and their role in the world.

Most of us learn to comply with the dominant gender expectations of our social group at an early age and, if we examine them at all, come to view these norms as natural and normal.[2] However, within each male or female social group, individuals may identify very closely with gender expectations, or they may not feel the need to conform. We refer to those who conform closely to gender expectations as "traditional."

"Traditional" men

Traditional men have not been served well by our mental health system. In part, this is because we've been slow to recognize masculinity as "culture" and to consider that culture respectfully.

Two decades of clinical work with men, and my recent research and work in developing the curriculum for a national program for male veterans returning from service, have given me insights into how viewing these clients through a lens of "cultural competence" can help us understand how to adapt our services to better meet the needs of male clients.

Over the years, researchers have proposed many models of ideal masculinity. In 2006, a review of the research on male gender norms noted eight prized attributes that define the ideal of masculinity in many cultures. These include: toughness, intensity, strength, competition, discipline, courage, sacrifice and aggressiveness.[3] Such ideals are often emphasized and exaggerated in settings where men take on demanding work in dangerous or difficult environments such as the military, policing or other traditionally male-dominated work environments.

These masculine ideals, although useful in some situations, do not serve men well in relationships, in caring for their health, in admitting to difficulties, or in seeking assistance. The traditional man has a need to maintain the appearance of stoic competence (not showing feelings, appearing to be in control, etc.) when faced with experiences that overwhelm or bring into question their personal sense of control.

This may make it more difficult for these clients to admit they have a problem, let alone ask for help. To avoid feeling shame, traditional men may continue to comply with masculine ideals of being tough and unemotional on the surface by hiding personal struggles from their families, close friends, work colleagues and mental health professionals. These men may remain silent rather than seek help through therapy.

Research has suggested that across the globe, most cultures tend to idealize a tough, strong and unemotional image of masculinity; therefore, asking for help is often seen as an expression of weakness and frowned upon by those who seek to conform to this strong male role model.[4]

Despite the many advances we've made toward equality between men and women, the fact remains that there is a large population of traditional men who view having mental health issues as weakness, failure and a loss of control. So, the challenge for mental health professionals is to find a way to bridge the gap between men's need for help and the cultural pressures to stay silent.

Strategies to help the traditional man seek help

Multicultural theories and approaches can be helpful to create trust and reduce a client's fear of the stigma associated with seeking help. Therefore, it's important for mental health professionals to become culturally competent. This means that, regardless of their own cultural background and gender roles, mental health professionals must strive to communicate and practise in ways that respect and take into account the

language and cultural realities of the people they are working with.[5]

In my research and work with male military personnel and men in other traditionally male-dominated professions, I've found that the following changes to how I practise can make therapy more culturally appropriate:

- **Start with strengths.** For example, in the veterans groups we start the program with an exercise that focuses on their "proudest moment," rather than having them reveal the details of their trauma. Starting with a strength-based conversation rather than focusing on a deficit or weakness allows the men to get comfortable in the group and build cohesive respect-based relationships. This provides a solid foundation for later discussions about their trauma.

- **Make space for male language and metaphors.** For example, the men in our veterans program are often more comfortable referring to the program as a "course" rather than "group therapy." Similarly, one veteran talked about his trauma work this way: "Only the toughest belong here. We're in a battle. That battle is not done alone. You never go to battle alone."Adopting the language that men are more comfortable with, and using examples based on challenges they face, helps to engage men and move them to action. Metaphors based in work, sports, conflict and so on can be helpful.

- **Recognize men's preference for doing rather than talking.** Traditional men are often less comfortable than women when it comes to discussing their feelings or even admitting they have a problem. So, focusing on behavioural or "how-to" strategies can provide a familiar starting place to build confidence and demonstrate value in the therapy process. Self-regulation strategies (e.g., body and breath awareness) and self-coaching (cognitive therapy) exercises, which have a strong "how-to" component, can be high-value techniques in that they can be quickly mastered, so "fit" men well.

The foundation for effective work with traditional men, as with work across all cultural boundaries, is high regard and profound respect for the "other."

Mental health professionals can embrace the strengths present in the traditional male client and build on those strengths, while helping them break free of the need to project a competent, unemotional image. These men can then start to take responsibility for their lives and move toward healthier, more productive behaviour and relationships. When these clients—who are our fathers, brothers, sons or partners—are better served by culturally appropriate mental health services, we all stand to gain. v

Clinicians Supporting Youth

NAVIGATING THE EVER-CHANGING WATERS OF 21ST CENTURY CULTURE

Shimi Kang, MD, FRCPC

One of my young patients, who was just 10 years old, was struggling with low self-esteem and school frustration that led to depression and anxiety symptoms. When I asked him what he thought led him to feel this way, he said one thing (among many others) was being told he had a "pencil-holding deficiency."

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Dr. Kang is a psychiatrist and author. She is a Clinical Associate Professor at the University of British Columbia; the Physician Lead for Child and Youth Mental Health, Vancouver Coastal Health; the founder of the BC Provincial Youth Concurrent Disorders Program; and co-founder of the Youth, Culture, and Mental Health Fund for the BC Mental Health Foundation

This caused him to have messy printing and trouble with written output. Written output is important, but as a doctor with "chicken-scratch writing," to me this seems a big burden for a young child to carry.

I asked my research assistant Sajan, a 21-year-old student at the University of British Columbia, how often he wrote with a pencil or pen. In my two years of working with him, I'd never seen him hold a pencil or pen, as he took all his notes directly into his cell phone or computer. He said, "About once every 12 days—I do everything electronically." Shocked, I explained why I had asked the question, to which he replied, "Your patient needs to type. Kids these days are growing up in a completely different culture. I'm only 21 and I'm already outdated."

Culture is an extremely broad term that can apply to everything from aspects of ethnicity and language to age group and activities one is engaged in. Cultural identity is evolving, dynamic and an undeniable part of every human being. A child's "culture" of being a video gamer may feel stronger to a child than the culture of being of a particular ancestry.

Professionals would be well equipped to apply a cultural lens with all youth they work with. But this lens may not be what you think. It's not adapted for one specific cultural group. The 21st century is marked not only by

Just like educators are embracing the collaborative classroom helping professionals must also move to a 21st-century position of motivating and cooperative partnership.

break-neck-speed technology, but by global connectedness and the fall of authoritarianism. As we've seen with the fall of authoritarian political regimes in the Arab spring or in the "flattening" out of corporations, the 21st century is marked by a cultural shift from "top down" authoritarianism to a more "flat" collaborative approach.

Just like educators are embracing the collaborative classroom where teachers and students have shared responsibility, helping professionals must also move from an outdated approach of lecturing, directing, and instructing, to a 21st-century position of motivating and co-operative partnership. This is the world our patients are growing up in and expect to experience when they walk through our doors.

In my book, *The Dolphin Way: A Parent's Guide to Raising Healthy, Happy, and Motivated Kids Without Turning Into a Tiger*,* I identify three styles of interpersonal interaction: Dolphin, Tiger and Jellyfish. Tiger clinicians push and direct their clients, while Jellyfish clinicians provide no direction or advancement of goals. In this day and age, I recommend the approach of the Dolphin clinician.

The Dolphin clinician moves interactions from an authoritarian clinician–passive patient ("I am an expert on your life") to a shoulder-to-shoulder partnership ("You are the expert on your life and I can help you with some of your struggles"). Dolphin clinicians align as guides. They support yet also gently nudge the person toward clear goals for better health and well-being. This all happens within a professional healing culture of being empathic, person-centred and adaptable. The Dolphin techniques incorporate many strategies based on motivational interviewing but also include lifestyle and relationship tools I've developed over years of clinical practice.

Let's look at the issue of teen marijuana use. The Tiger clinician may say, "You really need to stop smoking pot. It is bad for your asthma and anxiety." The Jellyfish clinician may say, "What's going on with the marijuana use?" and allow the youth to go on about how much they enjoy smoking pot and how frustrated they are with their parents who are advocating for more control. The Dolphin clinician, however, will first establish a shoulder-to-shoulder stance of equality and teamwork: "I can see you really enjoy smoking pot, but it also seems to be causing some problems in your life. If you like, I may be able to help you with this." They may then explore—in a non-judgmental way—the benefits and drawbacks of marijuana use to point out the discrepancy of the positives and negatives of use and how they apply to the person's personal goals and the issue at hand.

In a world of an ever-growing generation gap, it is easy to be in shock of a young person's actions and behaviors. To combat this, Dolphin clinicians try to be curious, not judgmental. They do not direct or instruct but rather guide their patients to find their own personal solutions. They are playful in their approach, yet serious about moving forward on issues of health and well-being. For example, the Dolphin clinician may say, "Wouldn't it be great if you didn't have to smoke pot to reduce your anxiety? Because it really seems to be affecting your asthma and love of playing soccer?"

In over 10 years of working with teens and families from a variety of ethnicities, socio-economic classes and walks of life, I have found that looking for specific cultural tips is less helpful than applying universal human tools. For example, even though one may not speak the same language as their patient, appealing to fundamental human values of respect, autonomy, empathy, and humility are highly effective in any language even through a translator.

We humans, we are more similar than we are different. We all want to be understood and heard. And we all want to move forward in life—even angry adolescents. So, regardless of the cultural group we are interacting with, a collaborative approach that balances empathy and direction, and autonomy and expectation, will likely work. After all, regardless of our culture, we are all human. V

* The Dolphin Way: A Parent's Guide to Raising Healthy, Happy, and Motivated Kids Without Turning Into a Tiger. (Penguin Random House, April 2014.)

Mental Health Promotion Within Immigrant and Refugee Communities

Germán Blanco, Patricia Dabiri, MSW, RSW and Pedro Ramirez, BS, BSW

From April 2010 to March 2012, the REACH Multicultural Family Centre, located in East Vancouver, was the lead agency for Creating a Sense of Belonging: Mental Health Promotion Within Immigrant and Refugee Communities.

REACH partnered with immigrant-serving organizations, community centres and community health and mental health agencies to promote the mental health and well-being of specific high risk immigrant and refugee communities in Metro Vancouver. This two-year project was funded by the Community Action Initiative (CAI) (www.communityactioninitiative.ca), a provincially funded mental health promotion initiative to address substance use and improve the mental health of British Columbians.

A key feature of this project was the involvement of cross-cultural health promoters (CCHPs), also known as cross-cultural health brokers (CCHBs). (In this context, brokers interpret the culture of a client to the health care provider, and the culture of the health care system to the client, in the client's language.) CCHP/Bs are members of a cultural community who have knowledge of the values and beliefs of their own culture, as well as knowledge of the values and beliefs of the dominant culture in Canada. CCHP/Bs can bridge the cultural and language gap between them.

The CCHP/Bs in this project were community leaders from particular immigrant/refugee communities—that is, people who are well-known and trusted by members of the community and who are familiar with the socio-political dynamics of that community. They had Canadian credentials in social work or counselling and/or they were foreign-trained health professionals.

Based on community input, the project developed two components: social support groups; and capacity-building activities.

Germán, a Family Doctor who practised for 22 years in Colombia, currently works with the REACH Community Health Centre as a Cross-Cultural Health Promoter, focusing on chronic disease prevention and mental health promotion. A trained diabetes educator, he facilitates diabetes prevention and management groups and a support group for immigrant and refugee professionals

Patricia is manager of the Multicultural Family Centre at REACH and works with immigrant and refugee communities to develop culturally responsive health promotion programs and services. With a professional background in mental health, Patricia is committed to addressing the impact of the migration process on the health and well-being of immigrants and refugees

Pedro is a Cross-Cultural Health Promoter at REACH Community Health Centre, assisting members of the Latin American community to access health and other community services. He facilitates culturally responsive programs and services for the Latin American community, including peer support groups, drop-in counselling and practical-assistance sessions

Social support groups

CCHP/Bs from six diverse cultural groups worked within their communities to develop and implement culturally responsive social support groups. The social support of family and friends, including supportive relationships, involvement in group activities and social engagement, is solidly linked to mental health and well-being.[1]

South Asian Senior Women's Community Kitchen

Rashmi Rajema, CCHB from the Umbrella Multicultural Health Co-op, facilitates a community kitchen for South Asian senior women in New Westminster. The women come together over cultural recipes to share their experiences with how family and social roles are changing, and to talk about stresses related to settlement, culture and gender. Cooking together creates an open, supportive and sharing environment. "[The program] has allowed me to make contact with other women, who are like my extended family, with whom I can share and learn new things."

Afghan Women's Social Circle

Another Umbrella Co-op CCHB, Zarghoona Wakil, facilitates this group for Afghan women, with the aim of preventing isolation and helping them manage stress. The women meet in a community school located in a neighbourhood with a large population of Afghan refugees. They discuss topics and issues related to family and cultural conflict, such as parenting, religion and gender roles. Wakil conducted a survey to evaluate the group's perspective on the program, and found that 75% of the participants felt a better sense of belonging in the community they live in. "I'm engaged in the events of Afghan community; I cannot engage in others because of language issues."

Latin American Seniors' Social Club

This self-help and peer support group meets weekly for socialization, recreation and cultural activities. Activities include day trips, workshops on a variety of topics, on-site healthy meal preparation and leadership training. The group is governed by its own elected executive committee, and is facilitated by Pedro Ramirez, a CCHP from the REACH Multicultural Family Centre. Pedro reports that participants surveyed said they experienced reduced social isolation and felt more connected with their cultural community since joining the group.

Latin American Tertulias

This support group is for professional men and technicians who have come from Latin American within the past five years. German Blanco, also a CCHP with REACH Multicultural Family Centre, coordinates the prevention-focused weekly gathering. Using the Latin American cultural tradition of the tertulia (a regular informal social gathering where issues of common interest are discussed), the group has learned about anxiety, stress, depression management and how to overcome the loss they experience in a new culture. A survey indicated that 89% of the participants felt better able to cope with daily problems since joining the group, and feel safe in this country.

Mujeres Latinas en Accion (MLA)

This group provides a networking opportunity for Spanish-speaking immigrant and refugee women in a friendly and informal setting. Stella Castillo, the group facilitator, uses meditation and neuro-linguistic programming (NLP) methods to foster self-esteem, positive thinking and high morale. NLP is a model of interpersonal communication that teaches participants self-awareness and effective communication, and helps them to change their patterns of mental and emotional behaviour. "During an MLA meeting, I talked about how we faced many situations that made us a little depressed... I decided to come to this group to change the air I breathe."

Vietnamese Seniors' Health and Wellness Program

This group provides an opportunity to socialize, as well as a physical activity program (e.g., line dancing and ballroom dancing) that promotes a healthy and active lifestyle. Thoa Lam, another REACH Multicultural Family Centre CCHP, has also introduced a self-care component to the program, which includes healthy eating and stress management. Group participants report having increased energy to take care of themselves and their family. Group members have also expanded their participation in community activities such as yoga and relaxation, stress management, community outings and craft projects. "I used to be at home alone, but now I have met new people in the group, so I feel better, not like an old person."

African and Middle Eastern Women's English Support Group

REACH Multicultural Family Centre CCHPs Grace Wattanga and Inas Lasheen facilitate a social support group for women from a variety of African and Middle Eastern countries. Social support is provided through an adult literacy class that focuses on practising English. Improving the women's English increases their self-confidence and enables them to participate more fully in the community, increasing their

sense of belonging. "Coming to the group is like taking care of myself, and after coming to the group I feel I can take care of my family better because I feel stronger."

Helping communities promote mental health

The second component of the project involved activities to build the capacity of immigrant and refugee communities to promote mental health.

First, CCHP/Bs were trained, through a partnership with the Vancouver Coastal Health Cross-Cultural Mental Health Program, to better assist their community members who are experiencing depression, anxiety, major life stressors or transitions related to immigration and acculturation. They participated in a culturally adapted version of Changeways, a psychoeducational group therapy program that introduces clients to basic mental health self-care. The CCHP/Bs were able to use these principles in their group programs to assist and empower community members in managing their stress and cope with their depression and anxiety.

Then, CCHP/Bs and key community leaders took Mental Health First Aid (MHFA) training. MHFA is a world-wide program originally developed in Australia, which is available in Canada through the Mental Health Commission of Canada. MHFA training helps service providers to enhance the understanding of mental health issues in the Western context within immigrant and refugee communities, providing skills to identify and assist community members experiencing mental health problems, and for some, lessening the stigma associated with mental illness.

Many cultural communities have different understandings of mental illness. Having an awareness of the Western concepts helps the CCHPs and other community members to bridge the cultural gap when assisting members of their communities to access services and treatment. For example, the son of a woman who had taken the training was recently diagnosed with a major mental illness. She was able to understand that his behaviours were part of his illness and to support him in getting treatment.

Ideally, the training participants will spread knowledge and expertise on a larger scale among their related cultural communities and settings. This will increase the understanding of, and familiarity with, mental health issues throughout the wider community.

In the two years since the project ended, the Multicultural Family Centre has been successful in maintaining most of the social support groups with new funding from other sources. The concept of mental health promotion has taken hold in the centre, and has become, along with our Healthy Eating Active Living strategy, one of our "guiding principles" in program planning.

The increased level of awareness and understanding of the concept of mental illness among staff and volunteers from a variety of cultures has opened up a more respectful dialogue about mental illness. This is decreasing the stigma and creating a healthier environment for program participants affected by mental illness. V

The social support of family and friends, including supportive relationships, involvement in group activities and social engagement, is solidly linked to mental health and well-being.

resources

Multicultural Mental Health Resource Centre (MMHRC)
www.multiculturalmentalhealth.ca
MMHRC is a comprehensive Canadian resource for mental health topics around diverse cultures, ethnicities, languages, religions, and other important areas. You'll find information and tools as well as directories of service providers, local and national organizations, translators, and other key contacts.

Indigenous Cultural Competency (ICC) Online Training Program
www.culturalcompetency.ca
ICC, delivered by the Provincial Health Services Authority, is a series of online training courses for those who work directly or indirectly with Aboriginal community members. The core course focuses on knowledge, self-awareness, and skills. ICC Health and ICC Mental Health further focus on issues around health and mental health.

Creating Culturally Safe Care in Hospital Settings for People who Use(d) Illicit Substances
www.carbc.ca/PublicationsResources/Research/ResearchBulletins.aspx
This research bulletin from the Centre for Addictions Research of BC outlines principles of culturally safe care for people who use, have used, or are assumed to use substances. You'll learn more about the impact of stereotypes on health care, as well as practices that encourage respectful and inclusive care.

This list is not comprehensive and does not imply endorsement of resources.

BC Council for Families
www.bccf.ca
The BC Council for Families offers many resources for family members and professionals, including *Value Wars: Battle of the generations* (www.bccf.ca/all/resources/value-wars-battle-generations) which discusses intergenerational conflict between family members and proposes new ways to think about these tensions. You'll also find *Family Connections Magazine* for family service providers in BC (www.bccf.ca/family-connections). Recent issues include LGBTQ families and diversity.

Qmunity
www.qmunity.ca
Qmunity, BC's queer resource centre, offers programs and resources for youth, adults, and older adults, as well as education and resources around supporting safe and inclusive communities. You'll find information for community members who identify as LGBTQ as well as information for people who support or serve LGBTQ community members.

United Nations Human Rights
www.ohchr.org
The Office of the High Commissioner for Human Rights works to promote and protect human rights around the world. Learn more about human rights and find fact sheets, tools for educators, policy guidance, and other important resources.

Within Sight
www.heretohelp.bc.ca/newsletter/mynewsletters
A quarterly enewsletter from HeretoHelp for people who provide services to multicultural community members in BC. You'll find research and best practices, resources, events, and more.

heretohelp
Mental health and substance use information you can trust

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