

visions

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older adult immigrants
and refugees

life through depression—
depression through life

navigating alzheimer's
and other dementias

visions

Published quarterly, Visions is a national award-winning journal that provides a forum for the voices of people living with a mental disorder 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 Addiction Services, an agency of the Provincial Health Services Authority.

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I am currently doing some research on bipolar disorder and came across your *Visions* issue on cognitive-behavioural therapy. It's great to see that mental health is looking at incorporating counselling techniques as an adjunct to pharmacotherapy for those afflicted with mental illness. My sister, who suffers from bipolar disorder, is currently taking CBT counselling and doing much better. The CBT counselling she is receiving is specific to bipolar disorder. It's rather intense but she's reaping the benefits from the treatment. This of course translates into a reduction of relapses and better quality of life for her and her family. We realize the road will not be easy as she will likely have setbacks, but past treatment restricted to medication was not sufficient in and of itself.

—I. Brady, Valemount, BC

I am taking a moment in my day to say thank you for this issue [LGBT]. Also, if there is any way to get a note of thanks to "Alexander Singh." His article was wonderful to read. I know he and I are not alone in having experiences of Light, or other mysterious moments. When I have talked to some of my fellow professionals, they have looked at me like I am from space. I was greatly relieved to read that he validated the experience as more than an artifact of a brain or mental health issue. The few experiences I have had are real to me.

—Anonymous, Whistler, BC

editor's message

About one in four British Columbians is from a visible minority and most came to Canada in the last 15 years. So I'm delighted that *Visions* is covering the important and relevant topic of immigrants and refugees. But the only way to cover it well is to take off slices. This issue: older adults.

It was difficult getting stories for this issue. Mental health programs for this population are almost non-existent. Getting first-person accounts from immigrant seniors themselves was also a real challenge. It became easy to see how seniors, and visible minority seniors especially, can become invisible to the broader public and to the mental health and addictions system. Young people are getting more and more attention in our field. I fear the other end of the age spectrum has the short straw.

My family and I are immigrants. My grandmother joined us much later from India. She was widowed, alone and vulnerable over there. My mother struggled for a long time to get permission to bring her to Canada. Once here, Granny wasn't allowed to access most government programs for 10 years. She was never a full citizen. Although she was surrounded by family, she was lonely, isolated from others her own age. She couldn't drive and had panic attacks whenever she left the house. She practiced a religion that isn't well known here, so she worshipped alone. She still mourned the loss of my grandfather, and the loss of her country. She developed dementia after a small stroke, and then depression. We did what we could for her mental health problems, but she lost all lust for life. And the toll on our family, especially my mother, was enormous.

Immigrant seniors, like my granny, can easily feel stripped of power. We should never underestimate the courageous journey they face. And we can all do a whole lot more to respond to their needs—starting with listening.

Sarah Hamid-Balma



Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness

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Ethnocultural Elders and Mental Health

Guest Editor Soma Ganesan, MD, FRCPC

Over the past decade we have seen many positive changes to mental health service delivery, which are to be commended. These changes at first focused on adults, but later included the development of mental health services for families, youth and children.

Cultural diversity, however, is a fact of Canadian society. There is still a distinct lack of progress in mental health services for our ethnocultural minority elders. The most recent figures from Statistics Canada show that, over the next 10 years, the percentage of Canadians over the age of 65 with a non-English or non-French-speaking background will increase from 17% to 20%.¹ That translates into an increase of about 1 million to 1.3 million people. These are huge numbers—and are just the tip of the iceberg. We therefore need to reflect on our current geriatric mental health programs.

What it means to be an ethnocultural minority elder

Some of our ethnocultural minority elders arrive in Canada as immigrants and refugees during the family unification process: the adults come first, then children and finally the elders. A large majority of these elders will live with their families upon arrival. It's not rare to see three generations living together under one roof at the beginning of the settlement process.

The majority of ethnocultural minority elders, however, will have arrived in Canada as young or middle-aged adults and will have spent several decades living and working here. Yet they still face many challenges throughout their lifetimes because cultural adaptation is an ongoing process. They may retain the cultural

norms and values from their country of origin, where life experience and wisdom would have been generally respected, while younger family members adopt the norms and values of the adopted country. This results in a reduced status within families, neighbourhoods and communities. This loss of status means that the elders' retirement may differ radically from what they expected. They may find they don't receive respect and admiration in their new country or even in their own families.

In this sense, ethnocultural elders face a form of "jeopardy." In other words, they experience a series of personal, family and society challenges that influence mental health. These include personal devaluation, discrimination, alteration in family roles and socio-economic dependence.^{2,3} Clearly, ethnocultural elders face significant challenges with respect to their mental health.

Soma is Clinical Professor of Psychiatry and Director of the Cross Cultural Psychiatry Program, University of British Columbia (UBC), and Medical Director, Department of Psychiatry, Vancouver General Hospital and UBC Hospital. He is also Medical Director of Adult Mental Health Services, Vancouver Community Mental Health Services, and Physician Leader at Riverview Hospital



We have well-developed mental health services throughout British Columbia, but our ethnocultural elders still face major barriers to accessing appropriate services.

This is reflected in some of the recent statistics on global mental health and depression in ethnocultural minority elders. For example, older Chinese-Canadians report poorer overall mental health compared to older Canadian adults, and mild-to-moderate depressive symptoms are more common in South Asian older adults compared to older Canadian adults in general.⁴

Do our ethnocultural elders receive appropriate service?

The answer is clearly no. We have well-developed mental health services throughout British Columbia, but our ethnocultural elders still face major barriers to accessing appropriate services.

What do I mean by *appropriate* services? I mean *culturally responsible* services—services that meet the needs and interests of ethnocultural minority elders and that show respect for cultural diversity. Generally speaking, mental health services and policies do not reflect Canada's diverse demographics, let alone generational differences.

What does this lack of culturally responsible services mean? An initial assessment is often difficult to get as most mental health services are focused on youth and adults. Moreover, various forms of therapy, such as groups, self-help programs and cognitive-behavioural programs, are practically non-existent for ethnocultural minority elders. Similarly, due to the focus on adult and youth, they may not have

access to appropriate counselling programs in their communities unless they access them privately. This leaves only the medication approach provided by either family doctors or psychiatrists.

Ability to speak English is still needed to access and understand mental health services and treatment options.⁵ This language barrier to services is an obstacle that was discussed at the national level more than 20 years ago.⁶ Individual hospitals and care facilities vary in the quality of their language and interpretation services, ranging from untrained to professionally trained translators.⁶ And, interpreter services are commonly underutilized by mental health care providers due to the perception that they are expensive and/or difficult to implement.

What can be done?

First, it's nonsense that interpreter services are difficult to implement. Over 10 years ago here in BC, Fraser Health and Vancouver Coastal Health developed and implemented cost-effective interpreter and translation services together with the Provincial Health Services Authority. This language assistance is provided across all medical services.⁷

Services offered directly in languages other than English are still uncommon around the province. As a result of the increased number of ethnocultural elders in the Lower Mainland, however,

there are now several mental health services provided in other languages. The Cross Cultural Clinic at Vancouver General Hospital provides outpatient services, including psychiatric assessment and psychoeducation, in 13 languages and dialects. There is a cross-cultural mental health liaison program that provides services to members of five target communities: South Asians, Chinese, Latin Americans, Vietnamese and First Nations. Additionally, each mental health team provides services, individually or in group settings, in specific languages. However, outside of the Lower Mainland no such services exist, and in their place non-profit immigrant services groups provide limited support with respect to mental health needs. As a result, most ethnocultural elders outside the Lower Mainland must use mainstream medical services.

Other examples of culturally responsible services in the Lower Mainland can be found in the care home sector. One changed the menu to include ethnic food. Another had introduced culturally appropriate spiritual services. These kinds of small, positive changes can contribute to the mental well-being of elder clients.

Finally, policies must guide appropriate hiring practices with respect to our ethnocultural minority elders. Recruitment should target individuals from ethnocultural groups that reflect our ethnocultural elder population. In addition, a strong leadership component emphasizing culturally responsible care needs to be integrated into clinical and administrative training. This will lay a strong foundation for identifying agents of change and developing culturally responsible mental health services in the future. ▽

Improving Services for Multicultural Clients

MENTAL HEALTH COMMISSION OF CANADA RECOMMENDATIONS

Judith Ince

Immigrants and refugees arrive in Canada with bright hopes, yet these are often dimmed by hardships here. The Mental Health Commission of Canada (MHCC) has studied the mental health of multicultural communities.

The MHCC report title, *Improving Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Groups: Issues and Options for Service Improvement*,¹ indicates the four multicultural groups addressed in the study.

In addition to immigrants and refugees, MHCC includes people bound by the common customs, beliefs and ancestry of an “ethnocultural” community. The study also includes “racialized” Canadians; that is, those who are deemed to belong to a specific race. The ethnocultural and racialized groups have been in Canada for a longer time than the immigrant and refugee groups.

Findings

This new study considered a wide body of research, and held focus groups with members of multicultural groups. These communities face many social conditions that undermine their emotional well-being. Unemployment, job insecurity, low-status jobs and poverty are common, even though these people are well-educated. Their university graduation rates are more than twice the Canadian average, and these university grads hold half of all doctoral degrees in the country.

Researchers found that some parts of these populations have more serious emotional problems than others. Not surprisingly, immigrants and refugees

who have fled wars or natural disasters are at very high risk for suicide, depression and anxiety disorders.

Mental health problems are also especially common among racial minorities, second-generation Canadians and older adults. Racial discrimination is a daily stressor for many members of visible minorities, and can contribute to mental health problems such as depression. For reasons not entirely understood, the offspring of immigrants have higher rates of depression, illicit drug use and alcohol use than their parents.

Elderly members of immigrant, refugee, ethnocultural and racialized populations face unique difficulties, including high rates of poverty, which is a risk for poor mental health. Those who come to Canada late in life face particular hardship. Learning a new language, adapting to a different culture and establishing new social connections heavily tax their emotional resources. While many elders live with their children and grandchildren, the assistance and support they receive is offset by the isolation they experience while the younger generations are at work or school.

A number of barriers block immigrant, visible minorities, refugees and ethnocultural groups from getting the mental health care they need. Some

Judith has taught art history at Simon Fraser University and Emily Carr University of Art+Design and has worked as a reporter and freelance writer. She now volunteers for a number of organizations, including the Canadian Mental Health Association's BC Division



studies suggest that some members of these groups believe that mainstream mental health care is unlikely to respect their values and cultural expectations. Language barriers are also believed to deter these communities from asking for help. In addition, some parts of these communities believe that they are likely to be offered lower quality of care than other Canadians because of institutionalized discrimination against them. Mental illness carries a stigma among many, and some fear that seeking treatment will bring shame on themselves and their families.

When immigrants, refugees, ethnocultural or racialized Canadians do decide to seek treatment, poverty can get in the way. Marginal or unstable employment makes it difficult to book appointments with mental health professionals, and expensive psychiatric medications are often beyond their financial reach.

“I think old people are more at risk of mental health problems, because they are alone and cannot take care of themselves properly.”

focus group participant¹

Recommendations

The MHCC study recommends three linked approaches to better serve these groups. First, it urges all levels of government to coordinate policy and services among themselves, as well as with the private and non-profit sectors.

At present, there are any number of agencies providing similar services to the same communities. Without planning and coordination, however, services are often duplicated and inefficiently delivered. Any new mental health strategy also needs to include a way of measuring how well it meets its goals.

Developing policies to guide the creation, delivery and assessment of mental health services requires much expertise. The report recommends that a national panel of experts—academics as well as members of the communities served—work together on these issues. For example, close monitoring of, and research into, the aging of the ethnocultural population will help prepare for the demand on psychiatric services that are expected over the next two decades as the size of the aging population grows. Such information could be then shared via the Internet, so that the experts’ work is accessible to other researchers, as well as the multicultural communities.

The study’s second recommendation is that health policy planners, researchers and clinicians include representatives of immigrant, refugee, ethnocultural and racialized groups in both planning and delivering mental health programs. This would help ensure that services are relevant and useful in meeting community needs.

Finally, the study recommends that organizations providing mental health services to these groups be culturally knowledgeable. Staff members, from the reception desk to the board room, must understand, respect and accommodate the needs of the groups they serve. They must also build a workforce that is rich in diversity.

What’s working?

The Improving Access to Clinical and Community Resources for Multicultural Mental Health Care project (www.mcgill.ca/mmhrc) adopts these approaches. A project of the Multicultural Mental Health Resource Centre at McGill University in Montreal, it explores culturally sensitive ways for physicians to recognize and effectively treat mental health problems among multicultural groups.

Several provinces, including BC, Alberta and Newfoundland, provide health and other social services in many languages. In BC, for example, HealthLink (dial 8-1-1 or visit www.healthlinkbc.ca) offers interpretation in over 130 languages to connect callers with nurses, pharmacists and dietitians. The toll-free provincial Crisis Line (1-800-SUICIDE) and the Health and Seniors Information Line (1-800-465-4911) also have access to interpretation services.

In the United States, the Office for Minority Health has a website (www.omhrc.gov) that not only contains information about both mental and physical illness for consumers, but has a section on “cultural competency” to help physicians become better at working with multicultural communities. There is also a section with demographic and health profiles for a number of these communities.

To read the Mental Health Commission of Canada’s report, visit www.mentalhealthcommission.ca/SiteCollectionDocuments/News/en/IO.pdf. ▼

Making Connections Between Mental Health and Physical Illness

THE CASE OF AN ELDERLY CHINESE WOMAN

Han Zao Li, PhD

One often hears an elderly Chinese woman talking about her physical illnesses, but never about her mental health issues—because she is not aware that she has any. Even if she was aware, she would never admit that she has a mental health problem.

Reasons for this “non-admitting” behaviour could include: 1) belief or hope that over time the illness can be overcome or will simply go away, and 2) to hide it from family, friends, relatives and acquaintances. There is a cultural stigma around mental health, and once the stigma is there, it’s there forever.

In the Chinese cultural context, mental illness is often perceived as hereditary and not curable. A mentally ill person is called “*shen jing bing*” (神经病) or said to have disorders in the nervous system). Neighbours—and thus everyone—would shun the person with a mental illness, thinking it could be contagious and/or would bring bad luck.

Over my 20 years in Canada, I have observed that a mental health issue, if unnoticed and unaddressed, will eventually manifest as a physical illness. If our general practitioners (GPs) don’t see or don’t have time to diagnose the connection and address the root mental health issue, the treatment for the physical ailment may not be effective. I have collected numerous anecdotes to illustrate this point. The following is a made-up scenario, but is typical of many immigrant women in Canada.

The Case of Mrs. Zhu*

Mrs. Zhu was in her mid 20s when she came to Canada with her husband and their baby girl. It was her husband’s idea to immigrate to Canada, study for a master’s degree and then develop a career in this country.

Mrs. Zhu hardly spoke any English. While Mr. Zhu studied for his degree, she had to make ends meet by taking various jobs, such as waitressing in a Chinese restaurant and doing home care and house cleaning. And she had to leave their young daughter in daycare.

Han is a Professor of psychology at the University of Northern British Columbia. She has researched extensively in the areas of intercultural communication and physician–patient communication. Han’s historical novel The Water Lily Pond, based on her experiences growing up in Maoist China, is now translated into German

* Zhu is a pseudonym



After Mr. Zhu had completed his studies and found a professional job in Canada, Mrs. Zhu complained that her husband had changed into a “piece of silent wood.” He faced new difficulties in the workplace and didn’t share his frustrations with anyone, not even his wife, for fear of losing face. Mrs. Zhu became increasingly lonely as her husband, consumed by the challenges in his job, spent his evenings watching TV.

To cope with her disappointment, Mrs. Zhu started to spend her evenings talking on the phone with her female Chinese friends who were in similar situations. She also started to lose her temper easily with her husband. He didn’t even bother to argue with her; he simply ignored her. At one Chinese New Year gathering, Mrs. Zhu yelled at her husband for showing up late. He glanced at her with contempt and, without uttering a word, walked to the food table at the far end of the hall.

Forty years have passed since they arrived in Canada, and the couple are now in their mid 60s, with grey hair

and wrinkled faces. They have one house paid for, a second house for rental income and a grown daughter who excelled at university and found a high-paying job here in Canada.

Mrs. Zhu still feels shut out by her husband. For instance, he frequently sends money to his relatives in China without informing Mrs. Zhu. When confronted, Mr. Zhu simply says: “I made the money; therefore, I can do whatever I like with it.” Mrs. Zhu is speechless. “It’s true, you make more money,” she says, “but what about my sacrifices while you studied for your degree in Canada?”

To make things worse, Mrs. Zhu doesn’t feel close to her daughter either. Her daughter speaks fluent English, identifies herself more as Canadian than Chinese, and considers her mother ignorant of the issues in Canada.

About 20 years ago, when she was 45, Mrs. Zhu was diagnosed with “three highs”: high blood sugar levels, high blood pressure and high cholesterol.

Her skin is dry, her hair sparse, she suffers from insomnia and from time to time gets migraine headaches. She has been taking medication prescribed by a Western medical doctor for these ailments for many years, but the symptoms have not gone away.

Traditional Chinese medicine —a holistic approach

Let’s analyze Mrs. Zhu’s symptoms from the point of view of traditional Chinese medicine (TCM). In TCM, diseases are considered a reaction to the environment and other people, and diagnosis looks at lifestyle adjustment as well as strengthening health using herbs and physical therapies such as acupuncture. A patient is examined on three levels:

- biological—i.e., whether there is a personal and family history of the illness; the patient’s diet, lifestyle choices (e.g., whether they smoke, drink, etc.), physical activity, and so on
- psychological—i.e., whether there are recent and historical stresses, including chronic and acute worries
- social/relational—i.e., whether there are resolvable and unresolvable disagreements with significant others (i.e., the important people in a person’s life)

Mrs. Zhu does not have a family and personal history of her physical illnesses. In her case, it’s easy to see a clear connection between Mrs. Zhu’s mental and emotional (psychosocial) state and her physical illness.

Further observation of, and informal conversations with, Mrs. Zhu found the following behaviours: cleaning her house constantly, cooking more food than necessary, frequent shopping trips for items “on sale” or “for clearance,” being on the phone for at least



There is a cultural stigma around mental health, and once the stigma is there, it’s there forever.

one hour almost every evening, and actively passing gossip in the local Chinese community.

Although the connection between mental health and physical health is well-known,¹⁻³ we often fail to notice it in our daily lives. Mrs. Zhu's behaviours clearly signal that she may have an underlying depression⁴⁻⁵—not surprising given the strained relationship with her husband and the long-time stress associated with having immigrated to a foreign culture. Unresolved stress is also a known factor in high blood pressure, cholesterol and blood sugar levels.⁶

From the mind–body interaction point of view more common in TCM, we could help Mrs. Zhu look for factors contributing to her physical ailments. Her insomnia, for instance, might be related to her disagreements with her husband. If so, these interpersonal issues should be addressed. If harmony was revived in the marriage—or if Mrs. Zhu just had a friend, TCM doctor or community leader to talk to—she may be able to reduce her stress. This could, in turn, lessen her migraine headaches as well as other physical symptoms.

The TCM model requires us to shift our Western perception of physical illness from a biological perspective to a biopsychosocial viewpoint, which embraces mental health.

To do so would require family, friends and medical doctors to be more watchful in order to gain a better understanding of the causes of Mrs. Zhu's problems and help her find remedies. GPs are the first medical professionals patients seek help from. In cases such as Mrs. Zhu's, a GP's attention to factors other than bio-

logical may play a central role in searching for—and finding—a more effective treatment.

In conclusion, I propose that patients, GPs, as well as family and friends, adopt a biopsychosocial approach in viewing stress and illness. This would undoubtedly benefit not only Chinese immigrants, but also people of all cultural backgrounds. ▽

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Jarnail and Pritam's Story

Gary Thandi, BSW, MSW



Jarnail* was a proud man who had a difficult time admitting that his alcohol use was becoming a problem. What started as an occasional drink in the evening had now become several glasses of scotch throughout the day.

Gary currently works as a counsellor and manager at DIVERSEcity Community Resources Society. He is also a researcher with the Centre for the Prevention and Reduction of Violence at the Justice Institute, looking into effective intervention and prevention strategies for intimate partner violence in South Asian communities

* Jarnail and Pritam are fictionalized characters

He knew plenty of men in his village back in India who had an alcohol use problem, but he had managed to avoid that fate for most of his 65 years. Why, after recently immigrating to Canada, did it rear its ugly head?

Jarnail's family, out of concern, brought him in to DIVERSEcity Community Resources Society, where I saw him for counselling. They had noticed that his alcohol use was increasing and that he was spending more time by himself in his room, isolating himself from the rest of the family. They were also concerned because Jarnail suffered from high blood pressure, and they feared the impact on his health from mixing alcohol with his blood pressure medication.

As Jarnail didn't know what counselling was about, he was hesitant at first to divulge any personal information. Trust took time; he needed to first understand my role as a counsellor and to know that I wasn't there to judge him or tell him what to do. He would ask me questions about my family, which I understood as his way of trying to connect and understand me better. While he was still not sure how someone half his age could help him, he became willing to give me the benefit of the doubt.

Much of our initial discussions were around how life was in India and the role he had there, and how his role had changed since coming to Canada. In India, Jarnail worked on, and looked after, the family property for over 40 years, while his wife Pritam* had primary responsibility for raising the children. In Canada, he was staying home and looking after the grandchildren along with Pritam. He'd have preferred that his wife look after the children, but she had some health problems and therefore needed help. Jarnail also took great pride in his many decades of hard work. While he loved his grandchildren very much, he didn't feel the same sense of pride in looking after children. And, although he was happy to be in Canada, he missed the lifestyle he was used to in India, of getting together with other people in the village on a regular basis. In Canada, he felt much more isolated.

Jarnail was not alone in this—I had the opportunity to speak to Pritam about her experiences as well. Raising children was a task she was much more

familiar with, but she too missed the interconnectedness of her former life in the village. Whenever she needed medicine or any kind of assistance, there was always someone in the village to help. Now, without a driver's licence and not knowing how to get around, she had to wait until her son or daughter-in-law came home from work.

Jarnail and Pritam shared many of the same issues around adjusting to their new lives in Canada. One of the biggest differences, however, was Jarnail's use of alcohol. Back in India, it was acceptable for men—but not women—to drink alcohol; it was only when Jarnail's social behaviour in the household changed that his family noticed something was wrong. Pritam, on the other hand, kept everything inside, so it was harder for her family to recognize what she was going through.

I would say that all the immigrant clients I've seen have gone through some kind of role adjustment experience, though it can range from mild to quite drastic. The older the client—and, therefore, the longer that client has lived his life a certain way—the more difficult the adjustment to a new role and culture can be. This period of adjustment, which can last for years, is when misuse of alcohol and other substances, as well as the onset of mood disorders like depression, can occur. Mental health and substance abuse issues, in turn, will make the adjustment phase much more difficult.

Over time, Jarnail and Pritam were able to identify their adjustment stress. Through counselling and support, they began to understand that what they were going through was very normal. Jarnail recognized that he was with-

The older the client—and, therefore, the longer that client has lived his life a certain way—the more difficult the adjustment to a new role and culture can be.

drawing from his family and that his increasing use of alcohol was, in fact, increasing the stress he was feeling. And Pritam found great comfort in being able to talk about her stressors, rather than holding them all in. Once they understood what was bothering them, they were able to take steps to deal with them.

Jarnail decided to embrace his role as a grandfather. He still wasn't comfortable taking on a major child care role, but he was happy to assume the role of someone who could teach his grand-

children about their heritage and family traditions. Both he and Pritam were also able to locate and attend seniors' programs in the community, where they could speak their mother tongue and meet with other seniors. While not the same interconnectedness they had known in their village, it still helped them feel less isolated.

Jarnail's story isn't necessarily the rule—many immigrant seniors make new roles for themselves without turning to substances to cope. It is, however, still a story that is familiar to anyone who works with immigrant seniors.

Thankfully, there is an increased awareness in BC of the needs of an aging population, and more specifically, the unique needs of senior ethnocultural populations. Awareness is a good start, but more attention and resources are needed to help immigrant seniors, so their stories will turn out as well as Jarnail and Pritam's. ▼



Life Through Depression —Depression Through Life

By Ken Lam, as told to Stephanie Wilson

I was born in 1932, in Hong Kong. I have two older brothers, one younger brother and one younger sister. My father had a successful business as a wholesale herbalist. He was a stern and dominant man, somewhat like a dictator in the house. As a child, I was scared of him, scared to talk to him. My mother smoked, played mah-jong and went shopping with friends.

Ken is a retired doctor. He lives in Vancouver with his son and grandchildren

She was very active, but did not need to do housework because we had three live-in servants. It was a very typical middle-class family.

As a young child, I was very sick with dysentery and malaria. As a result, I attended kindergarten for two years and grade one for two years. My overprotective parents treated me as the weakling of the family. My inferiority complex must have had its origin in my childhood.

During World War II, Japan occupied Hong Kong. The memory of the horror of war—the dead bodies I saw from bombing and starvation, the brutality of the Japanese soldiers—could not be erased from my memory.

In 1943, we moved to Kwongchow in mainland China, just north of Hong Kong. This was where food was available. My mother suddenly developed acute glaucoma and became almost totally blind. This was around 1943, when I was in grade four. Since I was the oldest child living at home at the time, I had to be the “oldest brother” and help my mother. I learned to take care of myself.

It was very sad to have a mother who was blind. She couldn't do anything for

us or for herself. I felt very frustrated. It was like having no mother at all. We saw little of my father, as he often came home from his business late in the evening. I do not remember home as a happy place.

My mother became very depressed because of her visual impairment. She suffered from insomnia for the rest of her life. She worried all the time as a result of the war.

After the war, my mother found out that her brother, an army officer, had died. She cried for many days and became profoundly depressed. Her deep grief was very hard on me. That winter, the whole family moved back to Hong Kong.

Life after the war was difficult. My parents fought all the time. I can't ever forget their hostile shouts at each other at midnight. I woke up frightened and wept with my head covered tightly by the blanket. All I could do was hope for the sun to rise.

I must have been in some degree of childhood depression, but didn't know about it. Back then, we did not know what depression was. I know I developed a pessimistic attitude towards life.

It slowly turned into depression. Some say that depression is anger turned inward. There is some truth to this belief.



I just saw the negative side of things. When I was in junior high school, Christian evangelists came to preach at our Baptist high school. They preached about a Heavenly Father who loved us. This was exactly what I yearned for—a father’s love. I accepted Him with open arms (or vice versa).

After the war, my mother reconnected with friends who took her to church. She seriously switched from Buddhism to Christianity. I read a Christian devotional book to her daily because she could not read any more. It gave us both comfort and strength to face each new day—or, should I say, dark day. That helped both of us the most at that time. I read that book regularly even after I came to Canada.

I graduated from high school in 1952. I couldn’t go to mainland China to further my education because China was in political turmoil. Fortunately, two Canadian missionaries in Hong Kong helped me come to Canada in 1953. I was shy and nervous, and I could barely speak English. But I was so glad to leave an overprotective, unhappy home. I was like a bird that had flown out of its cage.

Student years

The missionaries arranged a boarding home for me in Winnipeg, Manitoba. My landlady, Mrs. Fraser, was a kind, hard-working Christian widow. She treated me as her own grandson, with love and affection. This was something

I’ve always yearned for. I studied science for three years in Winnipeg, then moved to Vancouver, BC to attend medical school. My father sent \$400 a year for living expenses, so I had to make the rest myself. Fortunately, I was able to find work every summer.

During my years in university, depression was not a problem. I was occupied with studying. But it was the longest, hardest decade of my life. Life consisted of studying seven days a week, sleeping for eight hours a day and going to church on Sundays. There was no time for fun or relaxation. I remember seeing only two movies in those days.

After medical school

Starting in 1963, I worked as a family doctor at a clinic in Cowichan Lake on Vancouver Island. I married in 1964 and left Cowichan Lake the next year. In 1966, my wife and I moved to Boston so I could complete a one-year residency at Boston Children’s Hospital.

Building my family in Vancouver

My wife and I moved back to Vancouver in 1966, where I continued to work as a general practitioner. I think it was in the early 1970s when I began to experience depression. I became cranky, upset easily. That seemed to be the first sign. I would become unhappy with minor things in daily life, like if I didn’t like the lunch my wife packed. I held all these feelings inside. I began to realize that I was impatient, had a quick

temper and wanted everything done perfectly—the same characteristics of my father. My wife was gentle and mild, and afraid to reason with me because I always wanted to win the argument. I blamed myself and would feel unhappy and angry for many days. It slowly turned into depression. Some say that depression is anger turned inward. There is some truth to this belief.

I also had sleep deprivation. It was a busy life. There were no full-time doctors at hospital emergency rooms, so it was not unusual to get up at night to make house calls. By this time, I was the father of two children. And there were other problems: my wife and I had some relationship problems, and my parents came to visit every year. This was stressful, and I was very angry. There was a lot of infighting among leaders at my church. Some people didn’t treat the pastor well, and I stood up for him. I lost friends over the disagreements and felt guilty about the conflicts.

My own family doctor was insensitive to my needs, so I switched to another doctor. This doctor was also a former classmate in medical school. My classmate saw right away that I was suffering from depression and lack of sleep. I was in my late 40s or so. He gave me a tricyclic antidepressant to try. I felt better within a few days. The depressive feeling was completely gone and I could sleep again. Life became wonderful! Unfortunately, I developed very unusual side effects after only a month. I tried a different antidepressant, but it also caused side effects. I had to discontinue them and live with the depression.

My wife was diagnosed with breast cancer in 1981. She survived the cancer

but had severe depression and anxiety. I think she had a lot of anxiety about the cancer coming back, but I wasn't aware of her fear. My wife was seeing a psychiatrist, and I saw the same psychiatrist about my own depression. I tried other antidepressants, but they either didn't work or caused too many side effects. So I just put up with my depression.

My wife died in 1995 due to a second cancer. I felt such severe grief. In medical school, they didn't talk about grief. It was so unfamiliar and so bad. I was referred to grief counselling by my wife's palliative care nurse. I also listened to books on tape and read books on coping with grief. It took me eight or nine years to move through the process. In those years, it was not possible to separate my feelings between depression and grief. I lost the person I loved the most in life.

In retirement

I officially retired from medicine in 2000. I was a bit scared of retirement, so my family doctor referred me to a psychiatrist who only treats medical colleagues. He was so kind, mild and gentle. I have a feeling that his personal character has healing effects on his patients. I started taking Celexa, a newer type of antidepressant. It took a few weeks before I noticed the good effects on my depression, but it did start to work. The psychiatrist indicated that some patients need to use the antidepressant indefinitely, and I now believe I am one of them.

I have happiness, too. My wife was an excellent role model to our daughter and son. Both of them are building a happy and harmonious family. I have four loving little granddaughters. I have no worries for them.

A couple of years ago, my son and daughter-in-law renovated and enlarged my house. Now I am living in a bright, roomy and comfortable basement suite. I have space to have ten people over for dinner. I am continuing the family tradition of inviting friends for a casual meal at short notice. I also have space to do artwork and painting—it was my wife's last wish—and space for a bible research library.

My son and his family live upstairs. In my old age, I am not alone. The two little granddaughters, ages three and five, come down every day and make joyful noises—for a little hand-out of banana chips or something sweet. ▽



within sight

a new resource for multicultural communities



News



Events



Resources



Programs

The BC Partners for Mental Health and Addictions Information have launched Within Sight, a new e-newsletter. Within Sight highlights new or useful mental health and substance use resources for multicultural communities, such as events, services, publications and agencies that help you access information in many languages.

Within Sight will also keep you up to date on new multilingual resources available on Heretohelp. It's published in English and is aimed at mental health and substance use professionals as well as people working in immigrant, refugee and multicultural services. Within Sight is free and delivered to your inbox every two months.

To sign up, visit www.heretohelp.bc.ca/other-languages or email withinsight@heretohelp.bc.ca.

The multilingual webpages and Within Sight are funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

ICARE: Immigrant Older Women— Care Accessibility Research Empowerment

RESEARCHING MENTAL HEALTH ISSUES

Melanie Spence, BA (Hon.), and Sharon Koehn, PhD

Sixty-six-year-old Mei Lin Wong looks after her husband, who has Alzheimer's disease, and her grandson, now a teenager. Mei Lin supports the three of them on her meagre earnings from a part-time job in a corner grocery store. She is still legally 'dependent' on her adult children who sponsored her eight years ago and lives in a house in Abbotsford that her children bought.*

They have since returned to China because they couldn't find the engineering jobs for which they were qualified. As her husband's needs increase and her grandson spends less time at home, Mei Lin finds she is increasingly anxious, especially now that she has angina. Although she is highly educated, Mei Lin's arrival in Canada at age 58 made it difficult for her to learn English. While there are many Chinese services in Vancouver, most are in Cantonese, not Mandarin, her native language. Also, with little time and income and no subsidized bus pass, she finds it difficult to travel into Vancouver. Mei Lin doesn't know how she will cope and doesn't know where to turn.

The ICARE (Immigrant Older Women—Care Accessibility Research Empowerment) team is a diverse group of health providers, researchers, multicultural settlement agency workers and older immigrant women. Initial funding focused ICARE research on understanding the situation of visible minority older immigrant women such as Mei Lin.¹ (Note: In our research we focus on immigrant groups only, because refugees often face very different issues, including experiences of trauma.) Since the majority of immigrants to BC come from Chinese-speaking (e.g., China, Hong Kong, Taiwan) and South Asian (e.g., India,

Pakistan, Sri Lanka) countries, we focus specifically on older women from these communities.

Almost 90% of older immigrants to BC are sponsored, usually by their adult children. Compared to immigrants to Canada overall, these "Family Class" arrivals have lower levels of education and English language ability.² Immigrant women over age 65, many of whom have never worked, are among the poorest in Canada.³ Older sponsored immigrants have poorer health than long-term immigrants and the Canadian-born population.⁴ And the risk of mental illness is higher among those who migrate after age 65.³

Several Canadian studies have found that older immigrant women

Melanie is the Research Assistant to the ICARE (Immigrant Older Women—Care Accessibility Research Empowerment) team. She brings her commitment to health and social justice to this community-based health research program

Sharon is a Research Associate at the Centre for Healthy Aging at Providence (CHAP), a Clinical Assistant Professor in the Department of Family Practice at the University of British Columbia, and leads the ICARE team with Dr. Karen Kobayashi (University of Victoria)

* Mei Lin Wong is a fictional character



from Chinese-speaking and South Asian countries are especially prone to depression.⁵⁻¹⁰ Yet we have little research that shows how social factors and discrimination combine to impact these women's mental health and their access to services.¹¹⁻¹⁴ We also know little about how to promote mental health in ways that are acceptable and accessible to older immigrant women and men alike.¹⁵⁻¹⁶ These are the gaps the ICARE team aims to fill.

Our approach to research

We begin with the understanding that health, including mental health, and access to health care are strongly influenced by social factors. These include gender, age, legal immigration status, visible minority and socio-economic status, and where people live.¹⁷ Experiences of discrimination (i.e., racism, sexism, ageism) are also relevant.

To fully understand the effects of gender on health, we will need to compare the experiences of immigrant men and women. We will be exploring social factors that affect mental health, including freedom from discrimination and violence, the support of family and friends, and income.¹⁸

Setting priorities

The ICARE team held consultations to identify research priorities for addressing mental health needs among older South Asian and Chinese immigrant women. These consultations took the form of: 1) a day-long forum with partners from the multicultural settlement, community, health service provider and academic sectors; 2) a three-part, Punjabi-language community radio call-in program; and 3) a three-hour Mandarin-language discussion session with older women.

The ICARE Community Mental Health team was formed in October 2009 to address the identified priority: mental health promotion among older adults, particularly women in these communities.

The immigration experience and mental health

For many immigrant women, mental health issues result from the stress of the immigration process. Resettlement stress, poverty, racism, intergenerational conflict and family separation are common experiences that greatly affect their mental health.^{3,19}

Canada's immigration policy mandates that sponsored seniors are not eligible for financial or social supports (i.e., Old Age Security, Guaranteed Income Supplement, subsidized housing, bus passes, etc.) for 10 years. This makes them dependent on the adult children who sponsored them, which is also a source of stress for many older immigrants.²⁰⁻²²

This policy leaves older immigrant women, who often have less experience outside of the home, especially vulnerable and dependent on their family sponsors. This sometimes leads to abuse and neglect.²³⁻²⁵ A common form of financial abuse occurs when older women are pressured to sign over their old age pension cheques—which they can receive after the 10 years—to their family sponsors.^{11,24} Abuse and neglect clearly impact women's mental health.

Shifting identity

Immigration can result in a considerable drop in social status and a shift in roles. As a research participant explained: "In India, the daughter-in-law is under the [mother-in-law], but here, the roles are reversed. . . Here,

the son and daughter-in-law have the money and, therefore, they are in control."²⁰

Role reversals often occur because the younger women here typically enjoy more independence outside the home, have a better understanding of Canadian society and its institutions, and speak more English than the older women. Decisions about matters of tradition, on which older Indian women were consulted back home, are not relevant here. And, well-educated older Chinese women find themselves unable to find work due to their age and lack of Canadian experience and English language skills.²⁶

Older immigrant women in several Canadian studies and in the ICARE consultations identified their role in Canada as limited to housekeeper and child care provider, with little respect associated with either.^{11,20,26-29} And there is often an expectation on the part of family sponsors that older female relatives look after their grandchildren without pay.

Child care obligations

ICARE consultations with older women confirmed that talking about caring for grandchildren is a way for older immigrant women to talk about mental health challenges.

Many of these women have cooked, cleaned and provided care for family members throughout their lives, which has limited their access to education and work outside the home. In Canada, they often lack the skills to access services and mental health supports.²⁰ Others, lucky enough to have had servants or access to education, find the adjustment to caregiving roles difficult. Like Mei Lin, they do caregiving out of

indebtedness to their sponsoring children or the need to occupy a role when opportunities to work are limited.

Consultation participants expressed that while grandparenting may be satisfying and is a role women want to fulfill, it is also tiring. As a result, the caregiving affects their physical and mental health.

One woman from the Chinese focus group explained that before she immigrated to Canada, she was physically active. But since immigrating here to look after her grandchild and perform household chores, she can't find time for these activities and has developed high blood sugar. Another woman said her family is too busy to help her when she gets sick. Older Punjabi women have similarly related how, with most of the younger women working outside the house, they aren't attended to by family members when they get sick.²⁹

Discrimination

Loss of status is also experienced through systemic occurrences of discrimination. For example, older immigrants from South Asia are economically disadvantaged compared to older immigrants from the United Kingdom and Australia. This is due to immigration policies that base the amount of Old Age Security on the country of origin.³⁰

Additionally, many older South Asian and Chinese immigrant women experience individual discrimination on a day-to-day basis because of their skin colour, age and gender. As visible minority seniors with few, if any, English language skills, older Punjabi women often resort to employment as berry pickers. This is sometimes voluntary and sometimes enforced by

their families. The working conditions can be extremely poor and the work itself hard, with negative consequences for their health. But the women are motivated to offset their indebtedness to their sponsors and to boost their self-esteem.²⁰

Loneliness and isolation

Immigrants lose the family and friend support networks they had in their country of origin, particularly if they come from rural communities. This loss contributes to depression among older immigrants, particularly women. Women are more often confined to the home here due to language barriers, lack of experience outside the household, caregiving duties and cultural taboos.^{11,20,28} As with Mei Lin, many are unsure how to find their way around new cities.

Older women might also feel a communication and culture gap between themselves and their children, grandchildren and the community at large. Participants in our forum related how the Punjabi or Cantonese that their grandchildren speak is imperfect

and rarely used in a way that shows appropriate levels of respect. They also complain that few community programs provide relevant English language classes for older adults.

A participant in our Chinese community consultation said she needs mental health support because her daughter and son don't want her to live with them. If women who live with their relatives are unhappy, they may not complain for fear of being "kicked out" of the family house and left alone.

Upcoming initiatives

In the fall of 2010, our ICARE Community Mental Health team will work with University of the Fraser Valley students to develop an inventory of services in the Fraser Health Authority. These will be services that address factors affecting the mental health of late-in-life immigrants from the South Asian or Chinese communities. We will then apply for funding to evaluate these services and identify how to develop mental health promotion that is relevant to older adults in these two communities. ▽

ICARE

The ICARE team is made up of researchers from the University of Victoria, University of British Columbia, University of the Fraser Valley, Langara College and the Centre for Healthy Aging at Providence Health Care. Included on the team are community representatives from DIVERSEcity Community Resources Society, SUCCESS and MOSAIC.

The ICARE Community Mental Health team includes some original ICARE team members, as well as new community partners from Mission Community Services Society, Abbotsford Mental Health Centre and the Mood Disorders Association of BC. There are government representatives from BC Mental Health and Addictions Services and the Ministry of Healthy Living and Sport, Mental Health Promotion.

ICARE is funded through the Women's Health Research Institute of BC. Additional funding and in-kind support has been provided through the BC Home and Community Care Research Network, the BC Women's Health Research Network and the BC Network for Aging Research.

iCON – Multicultural Public Health Education

BRINGING THE LATEST ON DEMENTIA TO METRO VANCOUVER COMMUNITIES

Helen Novak Lauscher, PhD, Elizabeth Stacey, MA, and Kendall Ho, MD FRCPC, on behalf of the InterCultural Online Health Network (iCON) team at the eHealth Strategy Office, UBC Faculty of Medicine

Patients with chronic diseases who are engaged in their own self-care (i.e., taking an active role in managing one's own health) can live longer, healthier lives. However, barriers exist for those within non-English speaking communities in BC and Canada who wish to practise self-care. For example, self-care resources may not reflect the culture of the community, and there is limited access to resources, including reputable web resources, in one's own language.

Helen is Assistant Director of Research at the eHealth Strategy Office. She leads an interdisciplinary team that explores technology and public engagement in health. Her PhD research explored youth empowerment through creative expression and media production

Elizabeth is a Research Coordinator at the UBC eHealth Strategy Office and an instructor with the College of the Rockies in southeastern BC. She applies her background in First Nations linguistics to helping communities develop culturally relevant health education

Kendall is Director, eHealth Strategy Office and Associate Professor, UBC Department of Emergency Medicine. His interests include translating medical knowledge into routine health practices, and exploring how health consumers, professionals and policy-makers can use information technologies to improve health services

Since 2007, the eHealth Strategy Office (eHealth) at the University of BC's Faculty of Medicine has presented five public education forums. These interactive forums are offered through an eHealth community education outreach program called InterCultural Online Health Network (iCON). iCON promotes communication between community members and health professionals in the Metro Vancouver area through culturally relevant, patient-centred health education. In addition to the health forums, iCON hosts culturally relevant, interactive websites and provides patient-friendly pamphlets.

Forum topics to date include diabetes, healthy heart and liver disease for Chinese-speaking communities, and dementia for Chinese- and Punjabi-speaking communities. There has been an overwhelming response, with forum attendance ranging from 700 to 1,400 people per session.

Tackling dementia

Recently, iCON hosted a public forum called Getting to Know Dementia—for the Chinese-speaking community (Vancouver, October 2008, 700 participants) and the Punjabi-speaking

community (Surrey, March 2009, 750 participants). These forums were offered as part of a project called Supporting Patients and Their Families in the Evidence-Based Management of Dementia: A Multicultural and Multimedia Approach, funded by an Alzheimer Society of BC grant.

Health providers who were also members of each community co-developed content for the forums with the assistance of an advisory committee to ensure cultural relevance. For example, case studies highlighting aspects of the "dementia journey" were collaboratively crafted with community members to ensure authenticity.

Promotion of the events via community media (radio, newspapers), posters and word of mouth ensured high turnouts at the events. Audience members at the forums were roughly one-third people living with dementia, one-third caregivers including family members, and one-third people interested in learning more to stay healthy.

Community members listened to doctors, pharmacists, a dietitian and a caregiver/caseworker discuss dementia management, treatment and

support. A host of other community supports—Fraser Health Osteoporosis, Fraser Health Falls Prevention, BC Transplant, Progressive Intercultural Community Services, Canada Safeway Pharmacy and Alzheimer Society of BC, for example—set up booths to share information about their services.

For the Chinese forum, speakers presented in either Cantonese or Mandarin and a live interpreter provided translation for the audience. For the Punjabi forum, most of the speakers presented in Punjabi, with an interpreter to translate for one speaker who presented in English.

During the breaks, medical student volunteers circulated among the audience and collected people's questions for the panelists on index cards. The medical students were from the different communities, spoke the languages and were interested in learning how best to serve members of their own communities. Over 400 questions were collected from the audience at the forums. Questions from both communities ranged from issues related to prevention to diagnosis and treatment. Nutrition and lifestyle issues ranked high among the queries, with an emphasis on how to access relevant resources. The panelists answered some of the questions live during the forum, and answers to the remaining questions were posted on companion websites in the appropriate language (see related resources).

Working to meet patient and caregiver needs

Surveys done during the forums indicate that participants have the desire to learn more about prevention and symptoms of dementia. They also want to learn more about prevention as well

as management of the disease for themselves and to help family members care for themselves. Participants indicated that they try to make healthy choices, but need culturally relevant resources available in their own language.

In response, eHealth has developed both print and web-based resource materials in Chinese and Punjabi, as well as English. The process of developing these culturally relevant resources on dementia involved extensive consultation with community-based health professionals and organizations.

Over 14,000 visitors have viewed the web materials to date, and over 1,500 printed information booklets have been requested by health professionals for their patients. The clearest marker of success is the communities' ongoing requests for more public events.

About the UBC Faculty of Medicine eHealth Strategy Office

The eHealth Strategy Office explores how information and communication technologies like cell phones and the Internet can support health care. New technologies have the potential to innovate how health education, research and practice occur. ▼

what is dementia?

Dementia affects how you learn new information, how you remember information and how you think and is the result of changes in the structure of your brain. Many seniors, their friends and their family worry about getting dementia or Alzheimer's disease. Dementia is not a normal part of aging, and not all seniors will develop dementia. Not all dementias are the same and not everyone with dementia acts the same way. In fact, many different diseases or conditions can lead to different forms of dementia. Some are reversible while others get worse over time. Alzheimer's disease is the most common dementia.¹

About half a million Canadians currently live with dementia. Dementia affects:

- 7% of people over the age of 60
- 55% of people over the age of 80
- 49% of people over the age of 90²

The rates for the Chinese- and Punjabi-speaking populations echo that of the general population.

related resources

Where to Access iCON Resources

For online resources in Chinese, visit www.iconproject.org.

To access these resources in Punjabi, visit www.ehealth.med.ubc.ca/dementia.

A booklet called *Getting to Know Dementia* can be downloaded from these websites (in Chinese and Punjabi). It is also available in English at www.ehealth.med.ubc.ca/_shared/assets/Getting_to_Know_Dementia_-_English_-_Second_Edition3056.pdf.

SUCCESS Provides an Antidote to Social Isolation of Immigrant Seniors

Danny Li



The SUCCESS Seniors Quality of Life Outreach Project helps isolated immigrant seniors get involved in community activities and form stable social networks with their peers.

Danny is Coordinator for the Seniors Quality of Life Outreach Project at SUCCESS. After graduating from UBC in November 2009 with a BA in social psychology, she volunteered in a Seniors ESL class at SUCCESS. Danny was later recruited to organize the outreach project for immigrant seniors

The program is offered by SUCCESS, a multicultural, multi-service agency in the Metro Vancouver area, and receives funding from the City of Vancouver. Social isolation was one of the major issues that came up when I worked in a SUCCESS ESL class for seniors. Many of the seniors told me they felt very lonely. Most spoke very little English, which created a huge barrier between their home environment and the outside world. Many of them were afraid to leave their houses because they feared getting lost, not being able to find their way home and not being able to ask for help.

Although basic ESL classes are usually provided to new immigrants, the English-only learning environment

sometimes prevents the seniors from fully understanding the course content. Additionally, some of the immigrant seniors reported that their children were too busy with work responsibilities to focus on their parents' social lives and personal well-being.

The SUCCESS Seniors Quality of Life Outreach Project was created to address the social isolation of immigrants, ages 50 and up, who live in Vancouver. By providing a peer social and support network, the program promotes physical and mental wellness.

Making friends with peers and the city

There are currently three seniors groups in Vancouver. We have two Mandarin-speaking groups (at Killarney Community Centre and Marpole Place) and one Cantonese-speaking group (at Marpole-Oakridge Community Centre). One SUCCESS staff person coordinates the groups, assisted by a small committee of senior group members. Group sessions are two hours long and scheduled on weekday mornings.

Outreach and information about the program is done through SUCCESS branch locations and community centres. Many seniors find out about the program through word of mouth. Those interested can drop in to a group at the most convenient location. The seniors are welcome to visit the program three times before deciding whether to join the group. They can also sign up by phone or email.

Our program uses recreational and educational activities to promote social well-being. The recreational activities we offer are diverse, incorporating both indoor and outdoor activities. When the weather is warm, there are regular outings, such as walks in the neighbourhood, or field trips to art galleries, parks, festivals and so on. In winter, our activities are mainly indoors at the community centre locations.


Discussion among our senior members is a good way to facilitate strong social bonds and improve our members' mental capacity. We encourage sharing the latest news and information about local issues and events, as this helps immigrant seniors adapt to mainstream community. For instance, construction of the Canada Line transit system and Vancouver hosting the Olympic Winter Games were frequent topics in the past year. A recent session focused on wasting resources and concern for the environment. Members are also able to talk about family problems they may have, such as stress around the workload they have at home, in this supportive group setting.

With the help of social workers and volunteers, our seniors organize celebrations for holidays such as Thanksgivings and Christmas, and birthday parties are held every three months. This is also a good way to strengthen the relationships among our seniors.

Each group offers different recreational activities, reflecting the seniors' preferences. For example, at Marpole Place, we offer an added two-hour beginners computer class. Basic techniques such as browsing the Internet, sending emails, uploading pictures and using writing pads are taught by volunteers

on a weekly basis. At Killarney Community Centre, the seniors group emphasizes learning English. This group is perfect for seniors who already have basic knowledge of English and would like to improve their conversation skills. The Cantonese-speaking group at Marpole-Oakridge Community Centre focuses more on artistic activities such as dancing, singing, practising Chinese martial arts and doing various handmade crafts. Recently, these seniors learned to make lanterns out of traditional red envelopes for Chinese Lunar New Year.

In terms of educational activities, guest lectures and workshops are presented every month to empower our seniors with knowledge about health issues and social resources. Again, the topics presented vary depending on the seniors' needs and desires, but workshops have included Vancouver's transportation system, the Canadian tax system and Canada's income assistance system. Workshop presentations also cover preventing physical and mental illnesses. We have had speakers from the Canadian Mental Health Association and have a session on Alzheimer's disease planned.




The SUCCESS Seniors Quality of Life Outreach Project was created to address the social isolation of immigrants, ages 50 and up, who live in Vancouver.

SUCCESS groups a success

The SUCCESS Seniors Quality of Life Outreach Project has been running for 10 years now and has benefited a great number of immigrant seniors in Vancouver. SUCCESS has started groups in a number of neighbourhoods, including at the Hastings and Thunderbird community centres and South Vancouver Neighbourhood house. Most of them have been aimed at Chinese speakers. This project initiates and supports new groups for three to five years until they are ready to be run independently by the seniors in the group.

It's clear that the quality of these seniors' lives improves through joining one of these groups. Members usually attend in the long-term. They build friendships and often arrange to do activities together outside of the group. They support each other. For example, if a member is absent from the group for some time, another member will visit them at their home to see how they're doing. They may lead activities if they have a particular interest or skill. And, ultimately, they value the group enough to keep it going on their own.

A new immigrant seniors group started at Riley Park Community Centre in April. It's a joint effort of SUCCESS and Little Mountain Neighbourhood House and welcomes both Chinese- and English-speaking members. This new group will empower even more isolated immigrant seniors with personal and social resources for adapting to their new home in Canada.

For more information, contact Danny Li at 604-408-7274 ext. 1083 or danny.li@success.bc.ca. 

Navigating Alzheimer's Disease and Other Dementias

RESOURCES FOR MULTICULTURAL COMMUNITIES

Lindsay Nielsen



Alzheimer's disease is a progressive and degenerative brain illness. This means that it causes changes in your brain that cannot be stopped. These changes in the brain significantly impair thinking and memory, cause mood and behavioural changes, and impact daily functioning (see sidebar on warning signs).¹

Lindsay lives in Vancouver

About 70,000 British Columbians are currently living with Alzheimer's disease or a related dementia.² These conditions, which affect people from all ethnic backgrounds, pose a significant—and growing—challenge. Nearly 10,000 of these people living with dementia are under the age of 65.² In the next 30 years, the number of people affected by dementia in BC is expected to more than double.³

The Alzheimer Society of BC reaches out to all British Columbians who are living with the disease, as well as

their families and friends. The society delivers support services, education programs and information throughout the province, and funds research for a cure.

Starting the multilingual 'conversation'

Receiving a diagnosis of Alzheimer's disease or a related dementia can be an overwhelming experience, and it can have a large impact on family and friends. Individuals affected by the disease report feeling a range of difficult emotions including fear, anger, sadness, embarrassment and disbelief. Reactions to such unwelcome news often include different phases, which are frequently experienced and re-experienced in any order. Phases of shock and numbness, disbelief and denial, anger and frustration, sadness, and acceptance are all common.

As Ruby Ng, director of marketing and communications for the Alzheimer Society of BC, points out, many people don't seek help for Alzheimer's disease or a related dementia. They don't realize that it's not a normal part of aging. Given the challenges associated with the disease, seeking help is an important part of accepting a diagnosis and moving forward.

Ng notes that stigma surrounding Alzheimer's disease and other dementias can prevent open discussions about the illness, get in the way of understanding and interfere with accessing

resources. People faced with these challenges may be unwilling to talk about the diagnosis because it undermines their feelings of self-sufficiency and control.

For non-English speaking populations, the challenge of getting help can be even harder, because most resources and services are designed for an English-speaking population.

In May, the Alzheimer Society of Canada launched its national awareness campaign, "Forget Everything You Knew," to raise public awareness and understanding of the disease. The campaign has produced television ads in Arabic, Chinese, English, French, Italian, Punjabi, Spanish and Urdu.

The Alzheimer Society of BC, mindful of the ethnic diversity of BC's population, is working to build connections with multicultural communities. Its educational resources, in print and online, are provided in Chinese, English, Japanese, Korean, French, Persian and Punjabi, Japanese and Korean. It also operates the Chinese Resource Centre in Vancouver.

The Chinese Resource Centre

Based in Vancouver, the Chinese Resource Centre provides the Alzheimer Society education programs and support groups in both Cantonese and Mandarin.

According to Ng, family members are often the first ones to ask for information and support. The centre offers the Chinese Families Caregiver Education Series for family members and informal caregivers. The two-day series consists of two seven-hour sessions in which participants are provided with information on Alzheimer's disease and related

dementias, useful communication strategies, tips for understanding changes in behaviour, community resources, stress and grief management, as well as advocacy and legal issues. This information series is made available whenever there is enough demand for it. At least 10 participants are needed to run a series.

The centre also organizes a Chinese Public Forum during Alzheimer's Awareness Month each January. Additionally, it conducts public information sessions on Alzheimer's disease, related dementias and brain health in various Chinese community centres and churches throughout the year.

Vivian Lam, support and education coordinator at the Chinese Resource Centre, notes that within the Chinese community there is often a lot of stigma associated with a diagnosis of Alzheimer's disease. She says that in Chinese culture, self-reliance is highly regarded, which means that many Chinese people don't want to ask for help when faced with Alzheimer's disease or a related illness.

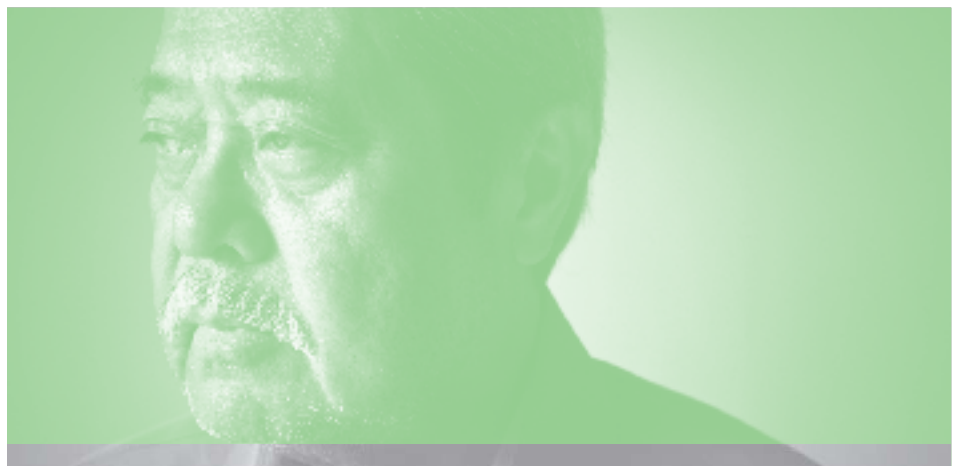
alzheimer's disease: 10 warning Signs

1. Memory loss that affects day-to-day function
2. Difficulty performing familiar tasks
3. Problems with language
4. Disorientation of time and place
5. Poor or decreased judgment
6. Problems with abstract thinking
7. Misplacing things
8. Changes in mood and behaviour
9. Changes in personality
10. Loss of initiative

Contact your doctor if you notice any of these symptoms.

Source: Alzheimer Society of BC at www.alzheimerbc.org

Lam believes the stigma surrounding the disease is stronger in the Chinese community than in the English-speaking community. Many Chinese people feel shame at talking about painful emotions and revealing their struggles to other people. Lam points



About 70,000 British Columbians are currently living with Alzheimer's disease or a related dementia.¹

out that when a Chinese family member is living with the disease, the affected individual, and their family, will often try to hide this information from friends and other relatives.

Given this context, the support groups at the Chinese Resource Centre provide an important network of support for members of the Chinese community. Lam says that in the groups, members feel safe sharing their struggles. She has seen an increase in the willingness of Chinese patients and families to discuss issues with peer groups and health care providers.

The centre offers a social support group for people in the early- to mid-stages of dementia. It also provides caregiver support. Support group facilitators and other staff provide the support groups with additional information in the form of brief presentations, information sheets and newsletters.

The facilitators are volunteers who have undergone an intensive training course offered by the Alzheimer Society. Many of the facilitators are former caregivers, and they often have backgrounds in nursing or social work.

Caregivers need support too

It can be very challenging to be a caregiver—whether a spouse, other family member or friend—of a person living with Alzheimer’s disease or a related dementia. The physical and emotional demands of the disease can make it hard for caregivers to stay connected to family and friends, which can then set the stage for isolation and loneliness.

The Chinese Resource Centre’s caregiver support groups provide a space where members can:

1. Exchange information and form

friendships with others affected by dementia

2. Access the most current information
3. Learn and share practical tips for coping with change
4. Decrease feelings of loneliness and isolation
5. Express feelings and be reassured that these feelings are normal
6. Find a sense of hope

Caregiver support group members draw on the experience and support of other members more than on the knowledge of staff. The principles of such a model are:

- All members of the support group are equally respected and valued
- The group is based on people talking as equals instead of being lectured to by an expert
- Members are encouraged to take an active role in the group to ensure that all the necessary tasks

are carried out. Tasks may include welcoming group members, making coffee and reminder phone calls

The Chinese Resource Centre’s caregiver support groups help members talk about the work they are doing, increase their feelings of competence and emphasize the importance of self-care. Lam says that members have expressed that the groups provide them a place where they feel understood and connected.

The long road ahead

Accepting a diagnosis of Alzheimer’s disease or a related dementia requires access to a network of supports to better understand the disease and develop helpful coping strategies. As the statistics show us, there will be many more people navigating this journey in the days ahead. ▽

what are “related dementias”?

Related dementias include vascular dementia, Lewy body dementia, frontotemporal dementia and Creutzfeldt-Jakob disease. We call these “related dementias” because their symptoms are similar to the symptoms of Alzheimer’s disease. Alzheimer’s disease and related dementias are also grouped together because they’re all caused by changes in the brain that can’t be stopped.

- **Vascular dementia** is the second-most common type of dementia. It’s caused by problems with blood supply to the brain and is often the result of a stroke
- **Lewy body dementia** is a type of dementia caused by changes in the nerve cells of the brain
- **Frontotemporal dementia** is a group of diseases that affect only certain parts of the brain
- **Creutzfeldt-Jakob disease** changes the structure of brain tissue and causes a very rare type of dementia

For more information on these related dementias, contact the Alzheimer Society of BC or talk to your doctor.

Source: BC Partners for Mental Health and Addictions Information at www.heretohelp.bc.ca

related resources

Alzheimer Society of BC: Provides information in Chinese, French, Japanese, Korean, Persian and Punjabi
www.alzheimerbc.org/We-Can-Help/Resources-and-Information/Non-English-Resources.aspx

For more information on Alzheimer's disease and related dementias, visit www.alzheimerbc.org or call the Dementia Helpline toll-free at 1-800-936-6033 (604-681-8651 in Metro Vancouver) from Tuesday to Friday, 10 am to 4 pm.

For more on the Alzheimer Society of BC's Chinese Resource Centre, call 604-687-8299.

For more on the "Forget Everything You Knew" campaign, visit www.alzheimer.ca.

Alzheimer's Disease International: Provides a list of numerous organizations that offer information in different languages
www.alz.co.uk/alzheimers/languages.html

Alzheimer's Australia: Provides information in many languages
www.alzheimers.org.au/content.cfm?categoryid=14

Family Caregiver Alliance: Provides fact sheets for caregivers in Spanish and Chinese
www.caregiver.org

Alzheimer Society of Canada: Provides resources in French and English
www.alzheimer.ca



mental health + substance use information now available in many languages



languages

Arabic	العربية
Traditional Chinese	繁體中文
Simplified Chinese	簡體中文
Farsi (Persian)/Dari	فارسی/داری
English	English
French	Français
Korean	한국어
Punjabi	ਪੰਜਾਬੀ
Russian	Русский
Spanish	Español
Japanese	日本語
Vietnamese	Tiếng Việt

Finding quality information on mental health or substance use can be hard—and it can be even harder to find information in other languages. We've launched 11 new web sections to help you find information you can trust.

Visit www.heretohelp.bc.ca/other-languages for information, fact sheets, self-tests and more. These multilingual webpages are funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

resources

Multicultural Mental Health Resource Centre

McGill University

www.mcgill.ca/mmhrc

Relevant resources for people living with mental health problems, families, community groups, professionals and administrators

Lessons from the Field:

Issues and Resources in Refugee Mental Health

The National Alliance for Multicultural Mental Health

www.refugees.org

A US publication that discusses best practices in assisting refugees and promoting well-being. It also includes case studies of refugees from Somalia, Kurdistan and Bosnia-Herzegovina

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Inter-Agency Standing Committee, a collaboration of United Nations and non-United Nations humanitarian agencies and organizations

www.who.int

These guidelines describe the mental health and psychosocial impacts of emergencies like civil conflicts, war and natural disasters. They provide everyone with an excellent discussion of a human rights approach to mental health and well-being

Responding to Older Adults with Substance Use, Mental Health and Gambling Challenges: A guide for workers and volunteers

Centre for Addiction and Mental Health

www.camh.net

Practical information on mental health, substance use and gambling problems for people who work with older adults

Multilingual mental health and substance use fact sheets

BC Partners for Mental Health and Addictions Information

www.heretohelp.bc.ca/other-languages

Multilingual factsheets and webpages provided by the BC Partners for Mental Health and Addictions Information. It is funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority

Promoting mental health for immigrants and refugees

Affiliation of Multicultural Societies and Service Agencies of BC *Cultures West*, Spring 2009 (volume 27, issue 1)

www.amssa.org

An issue of *Cultures West* devoted to mental health care and promotion for immigrants and refugees

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



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