Student: Avnish Goyani
Title: Canterbury's Culturally and Linguistically Diverse communities' view on mental illness
Supervisors: Dr Lynley Cook and Mastura Abd Rahman
Sponsor: Pegasus Health (Charitable) Ltd

Introduction:
Mental illness affects all cultures. But, the rate at which people from CALD communities access primary mental health services, is disproportionately very low. This is seen in Canterbury and across New Zealand. There is a wide variety of factors that can influence access. An important factor is people's views and beliefs about mental illness. Others include those related to services.

CALD is defined as anyone who does not speak English or Te Reo as their primary language, as well as anyone who has been or is being raised in a culture that is different from the predominant one where they live and for the purposes of this project are not Pacific people.

Aim:
Describe the views and beliefs CALD communities have about mental illness and their effects on help seeking.

Impact:

Improve our understanding of how different communities understand mental illness and in turn help to improve access to health services.

Method:
Firstly, a literature review on CALD views and beliefs regarding mental illness was done. Following this, 10 interviews were conducted with professionals involved in delivering mental health services to CALD clients and questions were asked about the CALD client's views and beliefs. 8 out of 10 interviewees came from a CALD background themselves. Interviews were transcribed and analysed thematically to produce relevant themes for discussion.

Results:
Historically, mental illness in most cultures has been interpreted spiritually and religiously. This is still the case for many people from many cultures in Christchurch. Religious causes of mental illness include being punished by god for sinning, having weak faith, or doing bad deeds in the current or a previous life. Other causes include possession by a spirit, witchcraft and various curses.

Some people from CALD backgrounds are also aware that mental illness can have a biological basis and can also be caused by stress and adversity. The extent to which people subscribe to a more biopsychosocial view is influenced by their level of exposure to modern education, with time spent in western society also playing a role. It's common for people to hold both spiritual and biopsychosocial beliefs at the same time. They are not mutually exclusive.

Many CALD cultures are relatively collectivistic. Collectivism emphasises conforming to societal norms, family values, controlling one's emotions, respecting elders and upholding the reputation and wellbeing of the family. Those who are mentally ill, can be perceived as being outside of the norm due to not being able to uphold some of these values and hence, can be judged negatively and stigmatised. Stigma is usually proportional to the perceived cause of the illness and also the severity of visible symptoms that result. This means that illnesses that do not display behaviour that is considered out of control or shameful are better tolerated and less stigmatising.

Stigma has a huge impact on help seeking. The person's illness can be reflected as the family's shame and this leads to wanting to contain and manage the illness within just the family. There is fear of being labelled 'mad' and 'crazy' and some think that the illness is incurable. The family is often the first and sometimes the only source of support.

Avoiding contact with friends, relatives and services can leave some families isolated. Even those who have sufficient knowledge about mental illness and no self-stigma, may not seek help due to public stigma. Often professional help is only sought out when symptoms become unmanageable.

Having decided to seek treatment, people are open to using medical services including medication and spiritual strategies if they are spiritual. These include maintaining current religious practices such as praying and reading holy texts, seeing a religious leader for intervention and even travelling to a place of spiritual significance. Many people find that doing these practices and the understanding and support of their family, very helpful for recovery.

Some CALD patients will talk about their issues in general emotional terms but there are many who express psychological distress through somatic complaints such as headaches, fatigue and various aches and pains. Reasons for somaticising include, firstly, it may be an acceptable way to show distress in cultures where psychological problems are stigmatising. Secondly, in a few cultures there is no equivalent language for certain psychological problems. Thirdly, overt expression of feelings is seen as a sign of weakness and is socially undesirable in some cultures. Finally, some people were not aware that their symptoms could be caused by mental health issues and this link can also be missed by some professionals.

Conclusion:
A culturally sensitive approach should be taken when engaging people from CALD communities, especially with those expressing somatic symptoms and a dialogue should be opened around how things are going in their life. Many people will disclose their issues very slowly and it may take time to first establish trust and comfort before issues relating to their mental health can be fully explored. They should be explored in the context of their views and beliefs, not just ours.