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A study of the cultural appropriateness of service delivery models in the Australian mental health system

Mong L. Connell
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A Study of the Cultural Appropriateness of Service Delivery Models
in the Australian Mental Health System

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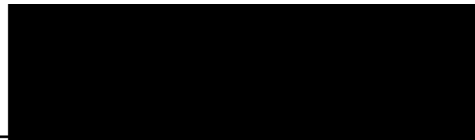
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Mong Leng Connell

ABSTRACT

This study is an attempt to examine the cultural appropriateness of the mental health system in relation to the Vietnamese refugee community in Australia. Culture and mental health, as widely acknowledged in the field of transcultural psychiatry, are closely linked. No aspect of the diagnosis or treatment methods can be justified without reference to the cultural traditions of the mental health system and the client. In a country like Australia, where multiculturalism is a dominant feature of the society, the need is even greater in incorporating culture into every aspect of the mental health system, if it desires to provide a culturally appropriate service to all immigrant groups.

Every immigrant group brings with them different cultural values and attitudes. Included in these are viewpoints about mental health/illness that can diverge distinctly from those belonging to the more prevalent Anglo-Saxon cultural norms. How the illness is perceived as to its cause, treatment to healing are different in most cultures.

According to the Australian Bureau of Statistics (1996), Vietnamese immigrants form one of the largest displaced people ever to be accepted into Australia as refugees. Their history of escape from the communist regime in Vietnam have sparked worldwide concerns about the state of their mental health. Their journey of escape is not without torture and trauma. Once settled into a country like Australia, they face many settlement obstacles. The cultural and social adjustments that they have to undergo have made them one of the most vulnerable and disadvantaged immigrant groups in Australia.

Faced with such a group that have a high predisposition to mental stress and anxiety, the question lies in whether the Australian mental health system is sufficiently informed and prepared to provide a service which has relevance and meaning to these people.

I argue that the system has not adequately provided a service to such a purpose. Although much progress and research has been done, it still operates

very much within a Western philosophy. Its traditions, values and attitudes reflect a worldview that make little cultural sense to these people. Its racist assumptions and attitudes which promote cultural superiority of the West has resulted in a system labelled as culturally inefficient. Racism has been socially constructed and entrenched within the system for many years and it's origins are lost in the history of Western culture.

Its mental health system is essentially monocultural. Culturally inappropriate diagnostic and treatment programmes and a shortage of professionals with the necessary linguistic, cultural and clinical competencies are just some of the deficiencies that exist within the system. Many training programmes have failed to evoke practitioners into questioning the effectiveness and cultural appropriateness of these fundamental structures supporting existing models of service delivery.

This study is done through a discussion of the history of racism, certain important concepts, for example, culture and mental health/illness and the social, historical and political experience of the Vietnamese. The rest of the research focusses on certain specific barriers of accessibility and concludes with how these barriers can be addressed. In doing so, it advocates for a totally non-racist approach from an international to a personal level of service. Only through this approach can the mental health system claim to provide a service that is culturally sensitive and meaningful.

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Table of Contents

Chapter 1	Page
1.1 Introduction	2
1.2 The Statement of the Problem	4
1.3 What Might be Wrong - Is it Racism?	9
1.4 Objectives of the Study	11
1.5 The Role of One's Experience	14
1.6 Prevalence of Mental Illness Among the Vietnamese	16
1.7 History of Racism in Psychiatry and Psychology	21
1.8 Torture and Trauma - The Refugee Experience	24
1.9 Consequences of Uprooting - The Torture and Trauma Experience	28
1.9.1 Manifestation of Post Traumatic Stress Disorder	29
1.9.2 Breakdown of Family Unit	31
1.9.3 Other Social Problems	34
1.10 Conclusion	35
 Chapter 2 METHODOLOGY	
2.1 Why Focus on Concepts of Culture and Mental Health/Illness?	38
2.2 Who are the Vietnamese Australians?	41
2.3 Where are the barriers?	44
2.4 A Way Forward - What Do we Need to Pay Attention To?	45
2.5 Limitations of the Study	48
 Chapter 3 THEORETICAL FRAMEWORK	
3.1 Introduction	51
3.2 Concepts of Culture	52
3.2.1 Theoretical Approaches to Cultural Studies	56
3.3 Concepts of Mental Health/Illness	59
3.3.1 Mental Health - A Further Discussion of its Concepts	60
3.3.2 Changing Views of Mental Illness in the Western World	61
3.3.3 Mental Illness - A Further Discussion of its Current Concepts	64
3.4 Different Understandings of Mental health and Illness Between Western and Eastern Cultures - A Comparison	67

3.4.1	Influence of Chinese Culture on Vietnamese Concept of Health and Illness	72
3.5	Conclusion	74
 Chapter 4 LITERATURE REVIEW		
4.1	Introduction	75
4.2	Historical/Political Events which led to the Refugee Exodus	76
4.3	Social Issues Associated with the Refugee Settlement	81
	4.3.1 Language Difficulties	82
	4.3.2 Unemployment	84
	4.3.3 Accommodation.....	87
	4.3.4 Family Life and Settlement.....	89
4.4	The Vietnamese Cultural Self	93
	4.4.1 Four Main Aspects of Interaction Guiding Social/Cultural Behaviour	98
4.5	Health Seeking Behaviour Among the Vietnamese	100
4.6	Conclusion	104
 Chapter 5 RESULTS OF FINDINGS		
5.1	Introduction	105
5.2	The Legislative Environment - National and State	106
5.3	Cultural/Linguistic Barriers	115
	5.3.1 Validity of Western-Based Diagnostic Instruments.....	115
	5.3.2 Issues of Cross-Cultural Counselling	122
	5.3.3 Issues of Cross-Cultural Communication	126
	5.3.4 Issues of the Use of Interpreters	129
5.4	Conclusion	130
 Chapter 6 DISCUSSION OF RECOMMENTATIONS		
6.1	Introduction	132
6.2	Paving the Way to a Non-Racist Approach.....	133
	6.2.1 Principles of Practice.....	134
	6.2.2 Examination of Self	135
	6.2.3 Incorporation of Tradition.....	137
	6.2.4 Cross-Cultural Transfer of Western Techniques	138

6.3	Cultural Competence - A Major Step Towards Effective Diagnosis and Treatment.....	140
6.3.1	Locating and Mediating the Role of Culture.....	146
6.4	Treating the Vietnamese Refugees - Awareness of Some Special Skills and Knowledge Needed by Staff	147
6.4.1	Service Expectation.....	147
6.4.2	Mistakes and Practice	148
6.4.3	Appropriate Practice Principles	149
6.4.4	A Way Forward - Cultural Healing and Traditional Treatment	151
6.4.5	Case Studies.....	153
6.5	Discussion and Recommendation for a Culturally Appropriate Screening Instrument	156
6.5.1	An Alternative Instrument.....	157
6.6	Conclusion	160
Chapter 7	SUMMARY AND CONCLUSION.....	162

Chapter 1

1.1 INTRODUCTION

In 1990, the Minister for Health, Neal Blewett, was quoted as having endorsed the need for much research to be done in the sphere of mental health among members of culturally and linguistically diverse (CALD) communities in Australia:

(We) believe that each of us should have an equal opportunity to achieve and maintain good physical and mental health, and that these attributes are essential to our full and equal participation in the Australian community. But we also accept that the reality does not match up to the ideal; that there remain serious inequities in our health care services and substantial imbalances in the health status of different groups within our community...The fulfilment of the health needs of people of migrant descent is a high priority...It should not be left to ethnic health consumers to struggle to overcome barriers to their access to mainstream health services; to change or compromise to suit the system. *We now expect the system itself to change so that we can offer equality of access to all Australians* (Minas, 1992 :252).

The above statement highlights what Dr. Jean Martin (1978), in her survey of post-1945 immigration settlement in Australia, observed about knowledge and research done on the mental health of immigrants. She noted that knowledge relating to the mental health of migrants was meagre and superficial. In the early days of mass immigration during the 1950s and 1960s, there was only scant reference to questions of immigrant mental health status. Whenever immigrant mental health did manage to appear on the public agenda, it was confined mainly to discussions on the adequacy of health standards of screening relating to immigrant entry (Jayasuriya, Sang and Fielding, 1992:1).

Jablensky (1994:59) observes that no major 'school' of academic research and teaching in culture-related mental health issues has emerged in Australia, despite the fact that there are a number of significant individual contributions to the field of transcultural mental health. There is a lack of continuity and little interdisciplinary concerted

effort in the study of the phenomena of psychiatric illness in relation to cultural context. In addition, he also notes that the psychiatric profession seems to have adopted an attitude of benign neglect towards the cultural dimension of psychiatric theory and practice.

Due to Australia's population becoming increasingly multicultural in the second half of the 20th century, considerable interest, however, has developed among health and medical practitioners on cross-cultural issues of mental health care and the psychosocial effects of immigration on mental health. This coincides with the renewed interest within scholarly circles, medical and non-medical, on cross-cultural issues of health care and the psychosocial effects of immigration (Jayasuriya, Sang and Fielding, 1993:1). Easthorpe (1989), Minas (1996), Fernando (1991) and Jayasuriya, Sang and Fielding (1992) observe that although the obstacles immigrants face in the resettlement process (and how these have impacted on their mental health) are of concern to policy makers and academic researchers, *the mental health status of immigrants remains poorly researched and documented.*

According to a publication by the Department of Immigration and Multicultural Affairs entitled 'Population Flows: Immigration Aspects' (1999), Australia's resident population estimated at 30 June 1997 was 18.53 million persons, of which 23.3% were born overseas. The 1996 Census shows that in Western Australia, of a population of 1,726,095 people, 475,856 were born overseas. Over one quarter are overseas born and more than half has one or both parents born overseas. Of those born overseas, 40 per cent speak a language other than English at home. They speak at least 120 languages, originate from at least 130 countries and bring with them mental health beliefs, practices and attitudes that are vastly different to those prevalent within the mainstream culture (Office of Multicultural Interests, 1998).

The large flow of ethnically diverse groups into Australia during post World War II has brought to the forefront the issue of the mental health of such groups within a migrational settlement experience in Australia.

Attention to the issue of the mental health status of immigrants and refugees raises issues as to how should we conceptualise and understand the nature of mental health from a cultural perspective. Consequently, it also raises the issue as to how should we then conceptualise, design and deliver appropriate and effective services.

1.2 THE STATEMENT OF THE PROBLEM

It is widely acknowledged that people from (CALD) communities consistently underutilise specialist mental health services. Stolk (1996), McDonald and Steel (1997) in Mihapoulas, Pirkis, Naccarella and Dunt (1999:16) observe that they have been under represented in psychiatric hospital admission rates and in community mental health centre contacts.

McDonald and Steel's (1997:35) statistical analysis, for instance, shows that migrants generally have a lower likelihood of hospitalisation for depression and related disorders. Table No. 1 not only indicates this, but it is also clearly evident that members of CALD communities have a much lower likelihood of hospitalisation compared to other migrants. For instance, Vietnamese migrants have been found to be one of the groups least likely to be hospitalised. Table No. 1 consists of statistical data gathered from all New South Wales hospitals from 1988 - 1994.

In another statistical analysis, McDonald and Steel (1997:72) also found that members of CALD communities are least likely to use community mental health services in metropolitan New South Wales for depression and related disorders. Table No. 2 shows that people from Asia are some of the least likely to utilise these services.

Table No. 1

Hospitalisation of People with Depression and Related Disorders by Country of Birth in New South Wales (1988/89 to 1993/94)

Source: McDonald and Steel (1997:35)

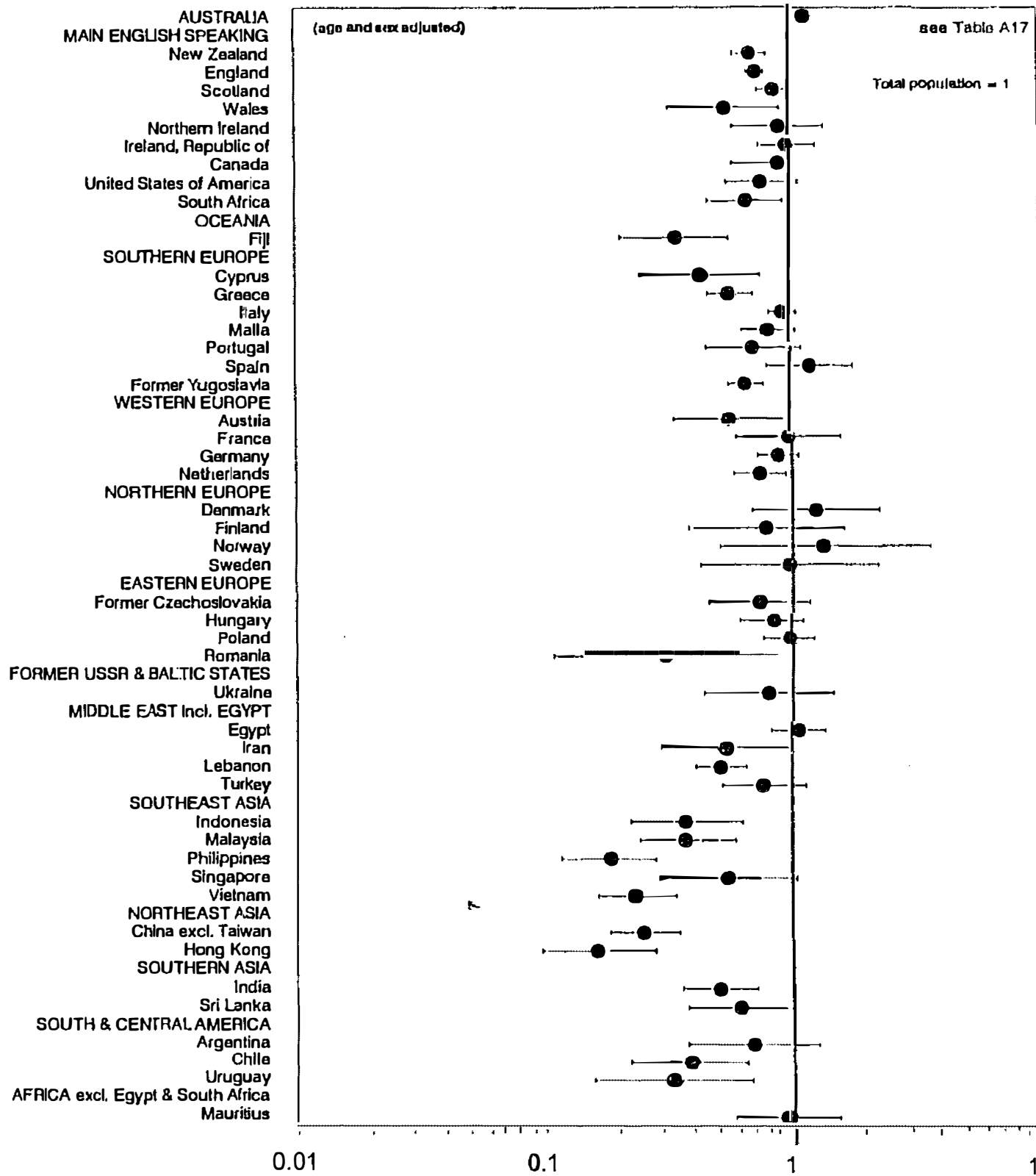
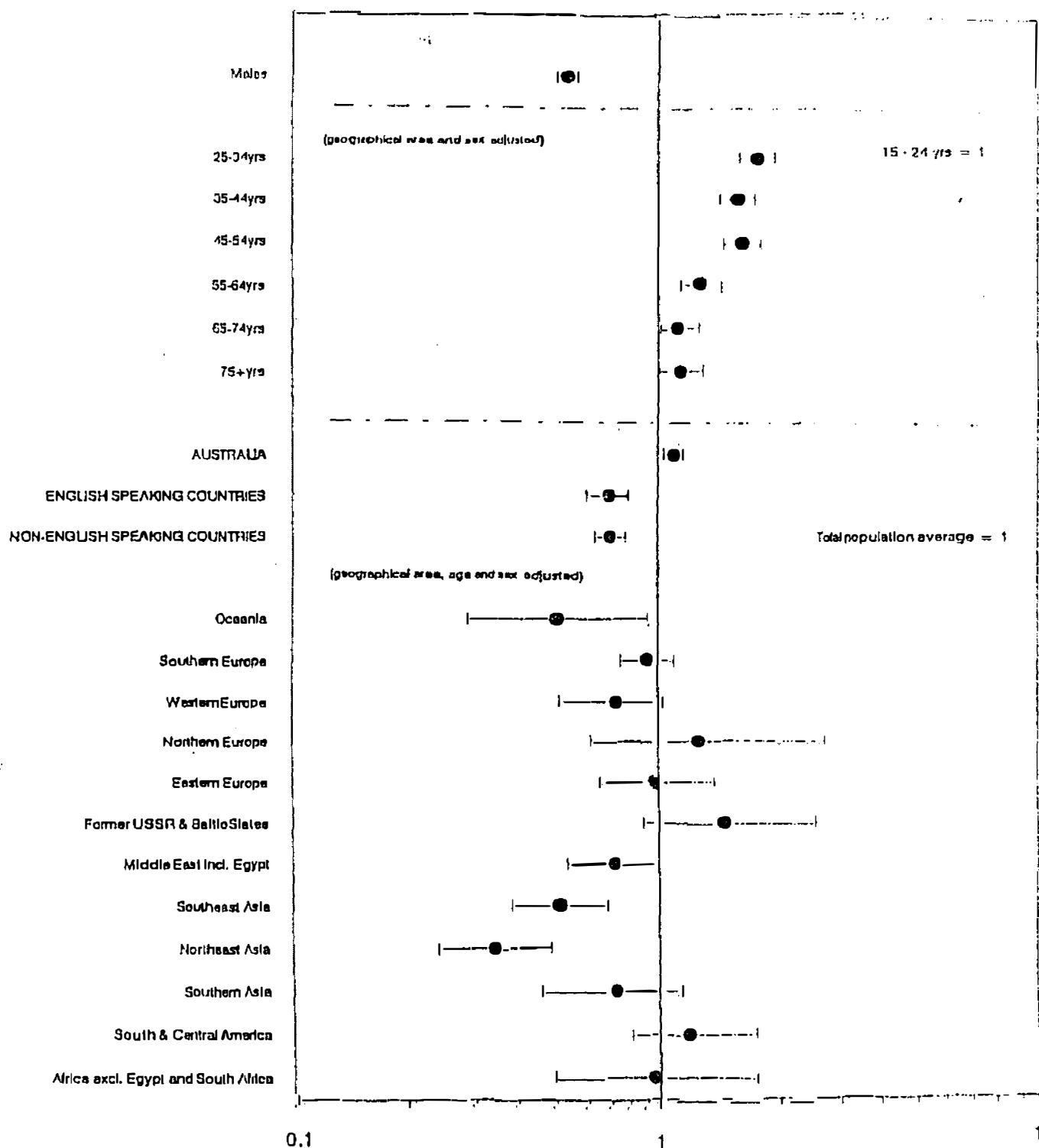


Table No. 2

Relative utilisation of Community Mental Health Services in metropolitan New South Wales by sex, age group and region of birth:
Depression/Related Disorders

Source: McDonald and Steel (1997:72)



In a recent Australian study, the pathways to mental health care of Indochinese immigrants were compared to those of Australian born. It was found that the former group took longer to receive psychiatric treatment for their first episode and tend to receive help mainly from family members or traditional healers rather than general practitioners (Long et al, 1999:15).

Barriers to mental health service access for people from CALD backgrounds can be analysed from two main perspectives:

- the characteristics, knowledge and behaviour of these people; and
- the culture of existing mental health services and the knowledge and behaviour of service providers.

The problem here lies in the fact that perceptions held by people from CALD backgrounds about mental illness, significance of symptoms, desirable patterns of care and role of health workers are often not shared by health service providers. Therein lies the mismatch between the ideals of both parties in regard to how to address these issues regarding mental health services.

The Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) observes that members of cultural minority groups are often disadvantaged as far as access to appropriate mental health services are concerned. Evidence received by the Inquiry from the various stakeholders - service providers, community workers and consumer advocates - indicates that mainstream services are under-utilised by people from CALD communities. Witnesses maintain that this is not because mental illness in these communities is any less prevalent, but rather, relates to three pertinent factors:

- reluctance by members of CALD communities to use the services;
- barriers to accessing services once a decision has been made to seek help; and
- the overall lack of culturally appropriate services staffed by appropriately trained mental health professionals to treat people from

CALD communities (Human Rights and Equal Opportunity Commission, 1993:730).

Silove et al, (1997:1064) maintain that other factors which may deter refugees from gaining access to mental health services include the stigma attached to mental illness, the lack of familiarity of these services and the preferential use of traditional healing methods. Other barriers point to the linguistic differences and cultural variations in the conceptualisation of mental illness and a mismatch between doctor and patient in their expectations of treatment. These factors contribute towards dissatisfaction with mental health care among refugees and reluctance to pursue treatment within mainstream services.

In a report of a consultancy to the Commonwealth Department of Human Services and Health on how to improve access of mental health services to people from CALD communities, Minas, Silove and Kunst (1993:5) outline the following specific deficiencies in the current situation:

- Inadequate mental health legislation and failure to implement existing policies.
- Poor quality of services currently available to CALD communities.
- Lack of involvement of CALD communities in design and evaluation of services.
- Inadequate access by CALD communities to information.
- Failure to adequately study stigma and to develop approaches for its diminution.
- Inadequate education of mental health professionals.
- Inadequate research.
- Inadequate information about mental health status and mental health service needs of CALD communities.
- Inadequate information about patterns of service utilisation by CALD communities.

Inadequacies appear to be found in almost all aspects of the mental

health system. It indicates the relative lack of interest by the government to address these issues in relation to migrant health.

1.3 WHAT MIGHT BE WRONG? - IS IT RACISM?

The question we now ask is one of whether cultural incompetence practices are a direct expression of racist attitudes or is it that it is merely a reflection of cultural incompetence? Cultural incompetence occurs when the mental health practitioner fails to apply culturally appropriate diagnosis and treatment to people of CALD backgrounds. They may display respect and sensitivity for other cultural practices, but lack the relevant knowledge, skills and experience to respond. As a result, they fall back on dominant Anglo-monocultural methods/models of practice.

I argue, however, that this inadequacy is not caused by cultural incompetence. Rather, it is caused by the *cultural racism that is deeply entrenched within the Australian mental health system*. Lorde (1994) in Dominelli (1997:7) defines racism as 'the belief in the inherent superiority of one race over all others and thereby, the right to dominance'. Cultural racism is centred on those values, beliefs and ideas endorsing the superiority of white, Anglo-Saxon culture. According to Fernando (1991:26), racism has been socially constructed over hundreds of years and its origins are lost in the history of Western culture. It forms the basis of popular racism that reinforces both institutional and individual racism. It renders services (like the mental health service) in Australia culturally inappropriate and is the root cause of cultural incompetence in many mental health services. The National Inquiry into the Human Rights of People with Mental Illness (1993) maintains that one of the reasons why members of cultural minority groups under-utilise mental health services is because of the overall lack of culturally appropriate services usually staffed by Western trained professionals

To put it bluntly, mental health theory and services are geared in every way to our English speaking Anglo-Saxon majority and members of ethnic minority groups simply must fit in or miss out (Human Rights and Equal Opportunity Commission, 1993:732).

The Inquiry went on further to quote one of the participants in the survey as stating that services should be sensitive to their cultural needs:

They seek quality, relevant and accessible services, and often encounter similar difficulties when trying to obtain services. However.... by virtue of their differing language, culture, and subcultural backgrounds (they) often require a differing approach to the provision of psychiatric services if they are to obtain accessible, relevant, quality services, which also uphold their fundamental human rights (Human Rights and Equal Opportunity Commission, 1993:730).

Mental health agencies seek to address some of the problems people from CALD backgrounds face in the area of accessibility of these services. It is widely acknowledged that they face obstacles in their search for culturally competent care to look after their mental health needs.

With respect to the above observation found in the study conducted by the Human Rights and Equal Opportunity Commission, mental health services has failed to comply with the principle of Access and Equity, a Commonwealth policy which aims to achieve the following objectives:

- to make programmes and services more accessible through the removal of linguistic, cultural, racist or religious barriers;
- to bring about equitable outcomes in programme and service delivery for all groups in this community, particularly those affected by barriers; and
- to increase the sensitivity of policy advisers and programme designers to recognise that diversity calls for greater flexibility and varied service delivery in order to meet the requirements of all clients equitably (Office of Multicultural Interests, 1998).

Fernando (1991:61) asserts that 'psychiatry' has grown through a Western historical process and hence so has its system of classification and treatment. This process is essentially one that has grown in a particular social, cultural and political climate and this climate has influenced and continues to influence psychiatry. The nosology of psychiatry is permeated by ideologies prevalent in Western society and is based on philosophical concepts such as materialism and the dichotomy

between mind and body. In considering diagnosis, two facts should be borne in mind. First, psychiatry is ethnocentric and carries with it the ideologies of Western culture including racism. Secondly its practises and diagnosis are very much influenced by the social ethos and the political system in which it lives and works.

Minas in Reid and Trompf (1990:250) argues that *Australia's mental health system is essentially monolingual and monocultural*. It's dominant Anglo-Saxon approach which is deeply entrenched in its structures, priorities and programmes of the health system does not reflect the diversity of the population that it has a responsibility to serve. Both the assessment and treatment programmes for people from CALD backgrounds, the shortage of professionals with the necessary linguistic, cultural and clinical competencies and the inadequacies of training programmes for mental health professionals to deal with these people has resulted in the system being labelled inaccessible or inappropriate when servicing people from CALD communities.

1.4 OBJECTIVES OF THE STUDY

It is against this background of inappropriate and inaccessible mental health system that this study aims to address several objectives. The study objectives will be framed within a positional context that existing mental health conceptualisations, theoretical discussions and service and practice strategies are a function of a racist approach to mental illness.

Racism is identified as the primary dynamic shaping of mental health services in Australia. This racism is reflected in the design and application of a dominant Western-Anglo-centred model of mental health/illness which has little meaning and relevance to the cultures/daily life of ethnic groups in Australia. The study objectives are shaped by the need to articulate and examine the nature of this racism and it's impact on the mental health needs of one ethnic community - the Vietnamese refugees in Australia.

The reason for the selection of this group is because, according to the Australian Bureau of Statistics of 1996 (ABS), Vietnam-born refugee immigrants form the largest single group of displaced persons entering Australia. From the fall of Saigon in 1975 until the 1990s, Vietnamese refugees began arriving in Australia by the thousands. The 1996 Census indicate that they numbered 10,080 in Western Australia, which was 6.7% of the national total. The overseas-born in WA totalled 475,673 persons or 27.8% of the total population. The relatively sheer size of this displaced population, their tragic experiences before departing Vietnam and the difficulties they encountered in the resettlement period have sparked concerns that there may be high levels of psychological distress among them (Mollica, Wyshak and Lavelle, 1987).

The objectives of this study are:

1. Examine the prevalence of racism within existing mental health services.
2. Analyse existing constructions of culture and mental health/illness.
3. Describe the historical/political experience of the Vietnamese which led to the refugee situation.
4. Examine issues of settlement and the culture of Vietnamese refugees in Australia.
5. Examine and critique barriers of accessibility and issues of cultural appropriateness within existing mental health services from a cross-cultural perspective.
6. Generate recommendations with the intention of eradicating racism and making the existing mental health services more culturally competent.

The remainder of Chapter 1 locates the study within the positional context of existing dominant mental health/illness paradigms as a form of racism. It also describes the refugees experiences with its consequences of torture and trauma.

In Chapter 2, the approach of the thesis to mental health will be discussed. A rationale for the focus of each chapter will be presented

which asks why these objectives are important and why they need to be answered.

Chapter 3 gives an analysis of the concepts of culture and mental health/illness. It also discusses the three main theoretical approaches to cultural studies - the universalist, evolutionist and relativist approaches - to provide an understanding of the different stand that researchers take on cultural studies. A comparison of the understanding of mental health/illness between Eastern and Western cultures is also discussed as a crucial factor in this study. The Chinese influence on the Vietnamese concept of health and illness is also mentioned as it provides valuable insight into the historical background of the Vietnamese concepts of mental health/illness.

Chapter 4 is a literature review of the Vietnamese in relation to:

- the historical/political events which led to the refugee exodus;
- social issues associated with settlement;
- the Vietnamese cultural self; and
- their health-seeking behaviour.

These discussions help to form an understanding of the background and culture of the Vietnamese. An awareness and understanding of the client's worldview is fundamentally crucial to the effective diagnosis and treatment of the illness.

Chapter 5 is a critique of the mental health system with regards to barriers of accessibility from a migrant perspective. It specifically addresses the failure of mental health services in implementing government policies as well as address cultural and linguistic barriers. Cultural and linguistic barriers are discussed in terms of the validity of Western-based diagnostic instruments in a cross-cultural situation, cross-cultural counselling and cross-cultural communication.

Chapter 6 seeks to generate discussions with the intention of eradicating racism and making recommendations for a more culturally competent mental health system. A more specific discussion on how to work effectively with the Vietnamese is also included in this chapter.

1.5 THE ROLE OF ONE'S EXPERIENCE

My personal experience as a migrant from a CALD background and my professional capacity as a Migrant Welfare Worker in a regional centre from 1990 to 1999 have provided me the opportunity to socialise and work for the Vietnamese community. As an immigrant who arrived in Australia under the Refugee and Humanitarian Program, I had my share of being alienated from the mainstream culture. Despite the fact that I could speak and understand the English language, being accepted and integrated within the mainstream culture required a lot of adjustment and compromise of my own cultural values. The reason for my application to migrate to Australia was propelled by the fact that my former husband was an Iranian Bahá'í. With the persecution of the Bahá'ís in Iran, we applied for refugee status and were accepted into Australia in 1985. Even though I could understand the English language well, the services available to assist with my settlement were found to be quite culturally different. My ethnic and cultural background upholds values and attitudes that are different from the dominant Western values prevailing in this society.

My reason for selecting the Vietnamese community was motivated by the knowledge that I gained from my professional work. I have found that the process of resettlement is even more difficult for these people. This is because most of them have extremely limited command of the English language. In addition, at least 90% of the Vietnamese whom I serviced were relocated here as refugees and many had suffered torture and trauma to varying extents during their journey of escape.

As part of my role as a Migrant Welfare Officer in this regional centre, I was responsible for helping them to settle into this community. I observed that many were reluctant to access the regional government and non-

government organisation's mental health services to help them alleviate their sufferings as a consequence of the torture and trauma that they had undergone. The consistent lack of culturally appropriate mental health services resulted in a severely disproportionate low number of Vietnamese utilising the mental health services in the area. According to a mental health professional in this local region, the number of Vietnamese accessing the service is virtually nil (informal communication).

Widespread reluctance to access mental health services by people of culturally different backgrounds is well documented in many studies in this area (Fernando, 1991; Jayasuriya, Sung and Fielding, 1992; Phan, Tuong, Silove and Derrick, 1999; Pope et al, 2000). It appears that although there has been a growing awareness that services generally are not catering for the cultural differences of clients, *many practitioners are not able to pull themselves away from the Western structures of service delivery*. These structures have little or no relevance and meaning to patients' cultural heritage and have particularly served as a strong deterrent for the Vietnamese refugees from utilising them. Cultural awareness training these days appears to only reinforce the Western model of delivering services because they usually stress on observable and functional services like the use of interpreters, awareness of clients' cultural differences, sensitivity on the part of practitioners etc. Although these issues are important they can have detrimental effects. They only serve to reinforce the practitioner to operate under the existing system but do not *evoke the practitioners into questioning the effectiveness and cultural appropriateness of these fundamental structures supporting these models of service delivery*. Nothing much has been done to question the philosophy, values and attitudes upon which the whole system is based on. An analysis of how the Office of Multicultural Interests understands cultural awareness training clearly illustrates the lack of discussions of such issues in this sort of training. According to this Department, cultural awareness training is characterised by:

'... raising cultural awareness and sensitivity. It emphasises the similarities as well as the differences between cultures' (Office of Multicultural Interests, 1998).

For instance, the typical Western approach of seeking help from a Western-trained practitioner who engages in 'talk therapy' does not sit well with the manner in which the Vietnamese patient usually solicits assistance. The cultural preference of the Vietnamese in this situation is that the practitioner is directive and prescribes medication. According to Phan, Tuong, Silove and Derrick (1999:87), traditional Vietnamese healing dictates that the patient should consult a traditional healer who will prescribe a variety of substance, organic and non-organic, as a means of treatment. Although Western medicine is also used in Vietnam, many also consult other traditional healers and these could include witchcraft, spiritual blessing from their religious elders and sorcery.

Harvey (1990:197) in his analysis of social research, points out that it is not enough just to touch the surface, but one should examine all attempts to get beneath the surface of apparent reality to reveal the nature of oppressive social structures. Helman (1992:156) supports this argument through his theory of macro-micro relation:

'Both micro- and macro-level explanations are by themselves incomplete and indeterminate in complimentary ways: macro explanations require 'micro-translations' and 'micro-foundations' require stable and enduring social contexts within which individual factors can be identified - such explanations must establish relations between various levels of analysis in order to resolve their indeterminacy. Both micro- and macro-level explanations must therefore be extended in the direction of the other, if they are to be explanations at all. Theories or research programmes that do not permit such extensions quickly degenerate into prescriptive metaphysics.'

1.6 PREVALENCE OF MENTAL ILLNESS AMONG THE VIETNAMESE

Despite a growing number of reports on the psychosocial status of Vietnamese people in Western countries, the extent of mental health needs of the community remain controversial (Holzer et al., 1989; Kinzie et al., 1982; Lin, Tazuma and Masuda, 1979) in Mollica, Wyshak and

Lavelle (1987). In their literature review of mental disorders and service utilisation among Southeast Asian refugees in the United States, Mollica, Wyshak and Lavelle (1987) state that:

'Very little is known about the prevalence of medical and psychiatric disorders in the Indochinese communities that have resettled in this country and elsewhere. Five years later, similar observations were made by McDonald (1992) in his review of utilisation of mental hospital services by refugee-immigrants in the state of New South Wales, Australia. Depending on the sampling frame, prevalence rates of common anxiety and depressive disorders amongst Vietnamese in Western countries have varied between 7.49% (Holzer et al., 1989) and 19.3% (Liebkind, 1993). The findings of such studies reinforce the comments of Van Duesen (1982) that, in relation to the relevant investigations, 'only a fraction of the studies are research quality, raising many questions than have been answered.'

Despite the current lack of reliable and comprehensive data however, it is widely accepted that mental illness is a major public health problem with various studies pointing to an average 20 per cent of the Australian population being sufferers at one point or another during their lives (McGorry, 1988, and Minas, 1991 in Pope et al, 2000). It is acknowledged that the burden of mental health problems is large and increasing. According to Andrews, Hall, Teeson and Henderson (Pope et al, 2000), 18 per cent of people aged 18 years and over in Australia report the experience of a mental health problem or disorder in the past 12 months and prevalence is highest for young people between 18 to 25 years at 27 per cent. Despite this, it is found that only about 38 per cent of those affected seek help.

Recent research has highlighted the concern that members of CALD backgrounds have an even higher incidence of under-utilisation of mental health services. It has been suggested that the experience of migration does not in itself predispose people to a higher incidence or prevalence of mental disorder (Canadian Taskforce, 1988; Minas et al, 1996 in Mihapoulas, Pirkis, Naccarella and Dunt 1999:13). However, a number of factors which may accompany the refugee migration experience do in fact, put people at greater risk. Some of these factors include:

- inability to speak the language of the host country
- separation from family members
- prejudice and discrimination in the host society
- traumatic experiences or prolonged stress before and during immigration
- low socio-economic status, or drop in socio-economic status after migration
- isolation from others of a similar cultural background
- lack of recognition of skills and qualifications acquired in one's homeland from the host country (Minas et al, 1996; Canadian Task Force; Ebrahim and Parsons in Mihapoulas et al, 1996:13).

Minas et al (1996) suggest that with the above factors in mind, it is reasonable to expect that people from CALD backgrounds are probably at greater risk of developing mental illness. Pickwell (1989) maintains that many of the circumstances which predispose immigrants to higher levels of mental illness than the host population are heightened in refugees. This makes them particularly susceptible to psychotic disorders, adjustment difficulties, substance abuse and other antisocial behaviours (Mihapoulas, Pirkis, Naccarella and Dunt, 1999:14).

Cox in Helman (1992:245) has summarised the three hypotheses that seek to explain this high rate of mental illness associated with migration:

1. Certain mental disorders incite their victims to migrate (the selection hypothesis).
2. The process of migration creates mental stress and may precipitate mental illness especially among susceptible individuals (the stress hypothesis).
3. There is a non-essential association between migration and certain other variables, such as age, class and culture conflict.

Aristotle (1995) in Long et al (1999:14) states that it has been established that 60-80 per cent of refugees suffer from physical and mental health problems related directly to torture experiences or associated refugee

related trauma. Up to 30 per cent of them suffer from severe forms of torture, and that a further 50% have experienced oppression which constitutes torture, albeit of a lower severity.

These refugees experience the ill-effects of migration to a much greater degree than voluntary migrants and may continue to suffer for a long time after settlement into Australia. Aristotle (Long et al, 1999:14) also argues that because of the nature of their experiences, they are more vulnerable to severe mental illness and unable to access services due to the fact that they are traumatised, distrustful of government services and unfamiliar with the English language. Even when they themselves may not have undergone torture, the trauma and deprivations suffered by refugees from similar cultural backgrounds can make them vulnerable to mental illness.

An Inquiry by the Human Rights and Equal Opportunity Commission (1993) into the human rights of people with mental illness found that a significant number of these refugees do experience physical and mental health problems as a result of their torture experience. No figures, however, are available to establish how many refugees have been victims of such experiences. Some witnesses suggest that at least 10 per cent and possibly as many as 15 per cent of refugees are suffering from mental illness as a result of maltreatment prior to their migration.

Professor Derrick Silove, a psychiatrist who has worked with many refugees, gave evidence that those who have come to Australia under the Humanitarian Programme are particularly at risk because of the human rights violation they have suffered:

‘They are dispossessed, dislocated, they suffer physiological disintegration and they arrive in a country where they become disempowered. Ten to twenty per cent of these people have been subject to formal torture and that’s probably an underestimate, but almost all of them have been subject to what we call “organised violence” which is a World Health Organisation term to cover a wide range of trauma to do with civil unrest, dispossession, persecution by authorities, famine, war and other forms of violence carried out in societies that are

disintegrating' (Human Rights and Equal Opportunity Commission, 1993:724).

According to Minas, Lambert, Kostov and Boranga (1996:44), a large scale study of adolescents and young adult Indochinese refugees in Melbourne indicates that about 32 per cent of a sample of 653 were diagnosed as having either definite or probable psychiatric disorder at initial interviews. These figures were twice that found in an Australian-born population of the same age and sex. Stein (1986) in Minas et al, (1996:44) points out that after the initial few years of resettlement, during which refugees tend to be preoccupied with re-establishing their lives, there tends to be a period of renewed distress and an increase in the manifestation of mental illness. Nann's (1982:11) study of the resettlement of Vietnamese also strongly supports these findings and links disorders to the extreme hardship and difficulties associated with resettlement after a period of torture and trauma.

As a comparison, Mollica, Wyshak and Lavelle (1987:1567-1568) in their treatment study of Indochinese refugees who have settled in the United States of America, found that they were a highly traumatised group with many having diagnosed as suffering from major affective disorder and post traumatic stress disorders. The researchers also found that women without spouses demonstrate more serious psychiatric and social impairments than other patient groups. Of those who were affected, it was found that they experienced traumatic events mainly during three distinct periods – during the war, during the escape and in the refugee camps.

Another study conducted by Kinzie et al (1990:913) on Indochinese patients using a programme implemented by the Department of Psychiatry at Oregon Health Sciences University also show similar trends. The study concludes that there was a high rate of post traumatic stress disorder among the patients and these rates were comparatively the highest reported in the literature for any group. They were reportedly even higher than those found among prisoners of war. Although these

studies have shown that Vietnamese refugees have a higher prevalence of mental illness, mental disorders may still be substantially under-reported by CALD respondents, given that those somatic expressions of psychological problems is thought to be common among such groups.

1.7 HISTORY OF RACISM IN PSYCHIATRY AND PSYCHOLOGY

Fernando (1988) stands out as one significant proponent who has examined systematically the concept of 'race' as an aspect of social reality which has permeated psychiatry theory and its practice. He argues persuasively that 'race' as a social construction and an ideology has been a neglected aspect of Western psychiatry (Jayasuriya, Sang and Fielding, 1992:43).

Fenton (1989) and others reinforces this belief and argue that the adoption of a predominantly mono-cultural approach may have led to the neglect of the role of racism in research conducted on the health of people from CALD communities especially in a multicultural society like Australia. In Fenton's (1989:4) own words, he notes that:

'an enduring and multifaceted aspect of the culture of the majority society is racism (which) constitutes a signally important inattention'.

These racist attitudes can be traced back to early thinking concerning mental illness and migration. It was mainly linked with notions of race and the supposed relative merits and deficiencies of different races and cultures. These ideas were characterised by ethnocentricity and racism (Littlewood and Lipsedge 1989 in Fernando, 1991). According to Fernando (1991:33), a clear example of this ethnocentric attitude was the common belief in the United States and Europe in the nineteenth century that the indigenous people of Africa, Asia and the Pacific did not suffer from mental illness. The supposed absence of mental illness in "primitive" people evolved into the idea that they were already in a sense, ill, childlike, deficient in intellectual development and in effect, mad. Europeans who became mentally ill were regarded as having regressed to a primitive state such as this. Those who studied mental illness among

non-Europeans had this overriding notion that their illnesses were quite simple and also different from those of the Europeans. Maudsley (1867) cited in Littlewood and Lipsedge (1988: 35) is believed to have said that:

'The morbid mental phenomena of an insane Australian savage will of necessity be different from the morbid phenomena of an insane European, just as the ruins of a palace must be vaster and more varied than the ruins of a long hut.'

Such was the depth of racism that has dominated the spheres of psychology and psychiatry in those days.

In the mid-eighteenth century, three distinct views about the minds of non-Western peoples were clearly discernible during the development of psychiatry. Rousseau's (Fernando, 1991:33) concept of the 'Noble Savage' proposed the view that 'savages' who lacked the civilising influence of Western culture were free of mental disorder. Others during this period also voiced similar views. One example was J.C. Pritchard (1835) in Fernando (1991:33) who, in his 'Treatise on Insanity', wrote that insanity among the Negroes of Africa and the native Americans was extremely rare. Aubrey Lewis (1965) in Fernando (1990) has pointed out that a second opinion was also evident in Europe about that time. The view was that non-Europeans were mentally degenerate because they lacked Western culture. A third viewpoint was voiced in the United States by psychiatrists arguing for the retention of slavery. The belief was that the black person was relatively free of madness in a state of slavery but became prey to mental disturbance when he is set free. The underlying supposition was that inherent mental inferiority of the black people justified slavery. However, Benjamin Rush, the father of American psychiatry, refuted such arguments and maintained that the capacity of black people could not be evaluated while they were slaves because of the effect on the mind of the condition of slavery (Plumber, 1970 in Fernando, 1991:33).

According to Fernando (1991: 41), Darwin's theory of evolution during the nineteenth century resulted in a model for racist theories of social and

psychological developments as well. Races were believed to have existed at different stages of development on a biological ladder of human evolution. An important proponent of this phylogenetic concept is Herbert Spencer. He cited Fryer (1984) in Fernando (1990:41) in which he noticed that 'primitive' races were having minds like those of the children of 'civilised' races and Thomas and Sillen (1972) as stating that social practices such as monogamy as characteristics of 'higher races'.

Nineteenth century anthropologists were strongly influenced by this type of thinking (Harris, 1968 in Fernando, 1991). Sociologists saw European civilisation associated with white skin as the 'culmination of the evolutionary process' (Fryer, 1984 in Fernando, 1991:41). Freud, 1930 in Fernando (1991:42) envisaged the development of civilisation being dependent on suppressing instinctual behaviour under the guidance of the super-ego, elaborated into a cultural super-ego. It was natural for him that the 'leadership of the human species' should be taken up by the 'white nations' and that 'primitives' have a lower form of culture. Some of Freud's 'primitives' included the Melanesian, Polynesian, Malayan people, Aboriginal Australians and many other black skinned people (Fernando, 1991:41).

Although Freud is racist in his thinking, it was Jung who introduced racist ideas more fully into psychological theories. Jung (1930) observed that the Indians had 'a very characteristic defect'. In postulating a psychological danger to white people living in close proximity to Blacks, he deduced the theory of 'racial infection' as 'a very serious mental and moral problem wherever a primitive race outnumbers the white man'. During his visit to the United States, he could not comprehend 'how the American descending from European stock have arrived at their striking peculiarities'. He focussed on the 'negro' as the cause:

'Now what is more contagious than to live side by side with a rather primitive people? Go to Africa and see what happens. When the effect is so very obvious that you stumble over it, then you call it 'going black' The inferior man exercises a tremendous pull upon civilised beings who are forced to live with them, because he fascinates the inferior layers of our psyche,

which has lived through untold ages of similar conditions' (Fernando, 1991:42).

Fernando (1991:197), in his concluding remarks about mental health and minority groups, emphasised that universally valid themes and the recognition of differences between cultures are fundamental to a meaningful and appropriate approach. In order to achieve this, he postulates three key imperatives that form the basis for an effective culturally appropriate model of service delivery:

- Racist conceptions of cultural forms and habits must be challenged. This demands an honest approach towards the non-racist opinions of cultural, religious and medical practices all over the world that is to do with preservation and maintenance of mental health. This ranges from family systems to idioms of stress, from beliefs in deities to religious ceremonies and exorcism rituals;
- All aspects of mental health must be held as cultural matters to be viewed in connection to the other aspects of cultures. Evidently, a medical viewpoint has a part to play as all cultures sees human distress and 'madness' as illness. It is necessary to recognise too, that medicine is part of culture as unlike Western thinking which believes that it is a system of its own and nothing to do with culture;
- Close attention must be paid to the spiritual needs of the people, their social experiences and their economic circumstances as seen in their cultural and political contexts. As Asian psychiatry is largely concerned with the spiritual development, an understanding of the Vietnamese belief system is a crucial step towards more effective diagnosis and treatment.

1.8 TORTURE AND TRAUMA - THE REFUGEE EXPERIENCE

When the war between the capitalists and the Communists block ended in 1975, Vietnam was in turmoil with the Communist victory. The consequences on the political scene of the Western world were quite dramatic. Many Vietnamese were forced to risk their lives and flee their country leaving behind the graves of their ancestors, their relatives and even their families to look elsewhere for freedom and democracy (Cuong and Bertelli in Thu, Cahill and Bertelli, 1989:30). In most cases, people left hurriedly and there was little time to prepare for the separation of their loved ones and familiar surroundings. Many spent days in small, poorly

equipped boats without proper food or shelter. Attacks by pirates were common. It is estimated that more than half the boats never made it to land. Women became the most vulnerable as many were victims of rape by pirates (Bochner and Furnham, 1986:98).

Hosking (1990) relates a story as told by a female survivor of torture and trauma:

'A woman was put into isolation. She was raped repeatedly by the guards. Electric shocks were applied to her nipples and labia. Her legs were spread apart and she was threatened with mice and spiders. An object was inserted into her vagina and anus until she fainted. She awoke in a pool of blood. Her left breast had been cut off.'

The influx of these refugees into other countries was at the highest peak in 1979 and 1980. According to the United Nations High Commissioner for Refugees (UNHCR), the definition of refugees is as follows:

A refugee is defined as a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country (Bennoun, Bennoun and Kelly, 1984: 9).

In Australia, the highest number of refugee intake was between 1975 to June 1988 when over 108,641 Indo-Chinese were accepted. The Vietnamese formed the largest group of settler arrivals from a non-English speaking background from 1976 to 1986 (Cuong and Bertelli in Thu, Cahill and Bertelli, 1989:30). From 1975 to 1981, all Vietnamese who arrived in Australia came under the Humanitarian Program as refugees. This percentage fell to 92.8 per cent for the years 1981 to 1986 and decreased even further to 45.1 per cent during the period 1986 to 1991 (Viviani, Coughlan and Rowland, 1993:22). Those who arrived after 1986 tend to settle here under the Family Reunion Programme which united those families that were split up due to the war in Vietnam. According to the Australian Bureau of Statistics (1996), Western Australia

has 6.7 per cent of the national total of Vietnamese in the whole of Australia.

The experience of torture and trauma are well documented in many books (Fernando, 1991; Thu, 1994; Cuong and Bertelli, 1989; Thu, Cahill and Bertelli, 1989; Green, 1995 and Furnham and Bochner, 1986). According to Santini (1987) in der Veer (1998:2-4), the term torture and trauma refers to:

Torture refers to violence directed against the physical and mental integrity of the individual. This involves extended and repeated physical and psychological torment which is aimed at persuading the detainee to provide the authorities with information which will incriminate himself or others, or at intimidating him and his social environment to such an extent that he will renounce further political activity. The aim is also to humiliate the victim and to deprive him of his self-confidence, his sense of identity, his willpower and his affect, thus reducing him to a numbed and helpless being. Traumatization refers to extreme, painful experiences which are so difficult to cope with that they are likely to result in psychological dysfunction both in the short and in the long term.

Physical torture usually takes place when the victim is helpless and totally at the mercy of his/her torturers. It usually involves the conscious and premeditated application of various forms, which causes pain and physical damage. Some of the more horrendous torment experienced by victims include hanging them up by the wrists or feet or both at the same time, exposing them to extended periods of cold, heat, strong sun or very intense artificial light or burning parts of their bodies with cigarettes or hot objects. Other forms of torture involve stabbing them with sharp objects, administering electric shocks to parts of their bodies or holding the victims under water often polluted with urine and faeces. Psychological torture is meant to evoke emotions difficult to cope with. These include imprisonment for an extended period of time without the possibility of contacting family or friends. Other psychological humiliation include being forced to witness others being tortured, executed or raped; long term solitary confinement or having to witness the cries and screams of others being tortured (der Veer, 1998:2).

These emotional and physical deprivations leave refugees more vulnerable than any other groups of migrants. The migration experiences themselves, as mentioned in the preceding paragraphs, are often filled with fear, trauma and tragedy. Many have spent years in refugee camps, separated from loved ones. Those who were lucky may experience a reunion, but only after many years of separation (National Health Strategy, 1993:32). Carrington (1994:196) describes the state of refugees in refugee camps in Malaysia as constantly tense, anxious, nervous and depressed. It is not unusual to find these psychological problems in refugees who have to live for at least two to three years in refugee camps after traumatic voyages from Vietnam to Malaysia. To survive in a refugee camp means to compete for everyday limited resources, and to be on one's guard against cheating, stealing and cruelty. This abnormal way of life further exacerbates the traumatic effects of the escape.

There is no privacy for women as they are forced to live in close proximity with men. As a result sexual relationships are easily formed and unwanted pregnancies are common. Sex is an habitual act to release tension, anxiety and anguish for both men and women. Women very often agree to have sex so as to get care and protection from men. The other common phenomenon is that relationships are formed when one party may have realised that his/her chance of resettlement is nil. By forming a relationship with someone who stands a better chance, it is seen as a way of getting resettled into another country and eventually to freedom (Carrington, 1994:198).

Their journey for survival is probably most traumatic for women, who are the most vulnerable victims. A report given by a female survivor to a practitioner reveals the torture and trauma that typically accompanied their experiences:

Ms. A left Vietnam in a boat with 32 people, nine of whom were female. A few days after they set out to sea they were met by five pirate boats. All nine females were abducted. They were separated into three boats. Ms. A was raped for five consecutive nights. Each night she was raped by seven pirates. She

attempted to commit suicide by jumping into the sea, but was grabbed by her hair and rescued. On the sixth day, the pirates abandoned her on a beach by a refugee camp (Mollica, Wyshak and Lavelle, 1987:1987).

1.9 CONSEQUENCES OF UPROOTING - THE TORTURE AND TRAUMA EXPERIENCE

Uprooting refers to the experience of being forced to leave one's familiar surrounding and to settle in a new and unfamiliar environment for an indefinite period. This usually brings stress and can cause various long-lasting adjustment problems. This is even more so when refugees have been forced out of their countries for fear of being persecuted (der Veer, 1998:4). For them, even though the initial phase of resettlement in a country like Australia may bring feelings of relief and safety, many eventually experience restrictions of being an asylum seeker. Feelings of powerlessness, sadness, anger as well as aggressive and self-destructive impulses may increase (der Veer, 1998:23).

Marris (1980:66) explains that uprooting can be seen as a crisis of reintegration. Our relationships, the way they are concerned as well as the emotional attachments, all have to be restructured. The structure of meanings by which each of us sustains the relationships to people, work and the physical and social circumstances on which our lives depend, are all disoriented. He likens this uprooting to roots which stand the risks of wilting and stunting due to the transplantation.

According to Cox (Lewis, 1981), there are distinguished distinct periods in their resettlement process. The first stage is somewhat of a 'honeymoon phase', which comprises gratitude and euphoria. It is also mixed with uncertainty and sometimes with suspicion. The second phase is a period of disenchantment. This is usually about 6-8 months after resettlement in Australia. During this time, they may complain of fatigue, sleeplessness, loss of appetite and stomach pains. Later, a phase of problem-solving and resolution follows in which, for some, it is a period for fully effective functioning.

Torture has no political, religious, cultural, gender, class or age boundaries. Torture and trauma have a profound immediate and long term impact on the physical and psychological health of those who have suffered it. A vast percentage of torture and trauma survivors suffer from extreme levels of depression and anxiety which manifest in a diversity of forms. These can include sleep disorders, recurring and intrusive memories, poor self-esteem, breakdown in family and personal relationships, intrusion into the identity development of children and adolescents, physical injuries which may require surgery and rehabilitative treatment and other debilitating consequences (National Forum of Seminars of Torture and Trauma, year unknown).

1.9.1 Manifestation of Post-Traumatic Stress Disorder

It is a common phenomenon that those who finally succeeded in getting accepted into another country carry with them extreme psychological, emotional and physical scars. Psychological problems include guilt of leaving behind loved ones, suicidal feelings, severe anxiety and depression, irritability, sexual dysfunction, sleep disturbances, nightmares, panic, phobias and impaired memory (Reid and Strong in National Health Strategy, 1993:33). These traumatic experiences can result in a specific kind of disorder commonly known as Post-Traumatic Stress Disorder (PTSD). The symptoms include re-experiencing of a traumatic event, for example, through recollections, dreams, and acting or feeling as if they were occurring. This is in combination with persistent avoidance of stimuli associated with the trauma. Symptoms of increased arousal such as difficulty in falling asleep, concentration problems or outburst of aggression are not uncommon (der Veer, 1998:28). These symptoms can either be manifested almost immediately after the traumatic experiences (called acute Post-Traumatic Stress Disorder if it occurred within 6 months of the experience) or much later (referred to as delayed Post-Traumatic Stress Disorder) (der Veer, 1998:28).

In a study conducted by Mollica, Wyshak and Lavelle (1987:1567) on the psychosocial impact of war trauma and torture on Southeast Asian refugees in an Indochinese Psychiatry Clinic in Boston, U.S.A., three important clinical findings on the psychiatric care of these patients not previously reported were revealed:

- the majority of these refugees had experienced multiple traumatic events;
- a high percentage of women without spouses demonstrated more serious psychiatric and social impairment than the others; and
- a high percentage of Indochinese psychiatric refugees suffered from major affective disorder and post-traumatic stress disorders.

As an illustration, in a case study presented by der Veer (1998:29), the patient who was diagnosed as having PTSD complained that he could not sleep and was afraid that he might become mad. He manifested this by expressing his loss of interest in his hobbies, felt alienated by his former friends and had felt like being trapped in a cage from which he would never escape. He also expressed his fear that his concentration could be affected as he was unable to read a newspaper or watch television for more than a few minutes and that he was having nightmares which were related to his traumatic experiences.

Refugees who have suffered from PTSD may also be affected by auditory hallucinations, which are not necessarily accompanied by other psychotic symptoms (Mueser and Butler, 1987 in der Veer, 1998:28). PTSD may also be accompanied by bizarre behaviour with a delusional and paranoid content, or by visual hallucinations that may be related to the trauma (Kinzie and Boehnlein, 1989 in der Veer, 1998: 28). Tactile and bodily hallucinations with a fright-inducing content have also been reported (Bailly, Jaffe and Pagella, 1989 in der Veer, 1998:28).

Some refugees, apart from suffering from PTSD also experience major depression. The most important common symptoms are a depressed mood and loss of interest and pleasure in most activities. Other symptoms also include the presence of delusions or hallucinations whose content may or may not be consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism or deserved punishment (der Veer, 1998:28). Hosking (1990:35) adds that other symptoms such as altered mood state, which is usually sad and depressed, sometimes irritable or detached and occasionally hypomanic are not uncommon. The inability to fall asleep and stay asleep, decreased appetite and a marked decrease in energy level are all common symptoms as well.

Physical consequences which results from these disorders can include cardiovascular disease, respiratory, gastrointestinal, nutritional, urological, genital, musculoskeletal, neurological, ophthalmologic, hearing, dental and pharmacologic disorders, drug and alcohol abuse and psychosomatic complaints (Randall and Lutz in National Health Strategy, 1993:33).

1.9.2 Breakdown of Family Unit

These sufferings are often compounded by social isolation, cultural alienation and economic hardship (Krupinski and Burrows in National Health Strategy, 1993:33). Refugees have to start learning a new language, seek housing and employment whilst all the time seeking reunification with members of family left behind. Feelings of homesickness and family breakdowns are not uncommon at this stage (Reid and Strong in National Health Strategy, 1993:33). Separation and painful memories from the past are viewed to be more serious than the numerous practical obstacles to resettlement. This unresolved grief and anxiety may predispose the refugees to depression and other psychiatric disorders (Furnham and Bochner, 1986: 104).

Like many immigrants, refugees suffer from culture shock, which according to Oberg (1960:177), is caused by the anxiety which results from losing all familiar signs and symbols of social intercourse. Marris in Coelho and Ahmed (1980:101), in his article entitled 'The Uprooting of Meaning', as noted earlier, explains that by removing themselves from their established cultural environment, they are like roots which have been uprooted and transplanted and which stand the risk of wilting and stunting. It destabilises the established structure of meaning by which each of us sustains the relationships to people, work and the physical and social environment which we are accustomed to. By uprooting this structure of meaning, Marris (Coelho and Ahmed;1980:59) believes that the individual will lose the elements on which the structure depends – purpose, attachment, regularity in events or conceptual coherence. The individual is torn between 'contradictory impulses, each reacting against the acute anxiety and helplessness of loss'. He or she will take refuge in the past, reliving the time when their lives were vital with meaning or trying, symbolically, to act as if the dead were with them. Dwelling in memories, clinging to associations and repeating as rituals the old routines are also not uncommon symptoms. On the other hand, Marris (Coelho and Ahmed; 1980:106) explains that they are also pulled by the opposite impulse to escape altogether from the past in order to begin a new life. However, this will only lead to an acute sense of betrayal because it denies the meaningfulness of the loss and of the attachments which made loss painful. The new life becomes hollow and its purpose without roots in a continuous identity.

As the cornerstone of Asian psyche and society, the family has continued to be the refugees' salvation and their most precious asset. Besides the benefit of material and economic improvement, it has provided support, reassurance and protection, to keep the refugees going in spite of all the struggles and upheavals. In this changing environment however, the family is now itself at risk of

being undermined and weakened as an institution. At the same time, it may turn against its own members and act as a stressor and source of problems for the individuals (Tran in Thu, Cahill and Bertelli, 1989:26). The psychological suffering of each family member has a profound effect on family relationships. Family members can be irritable, easily upset and relationships are often extremely strained (Hosking, 1990:43).

The new existence in Australia is not always favourable to a family life known back in Vietnam. Urban living tends to lead to fragmentation and dispersion of traditional Asian values. The influence of the Western culture pushes for individualism and affluence reduces the need for interdependence. In practice then, families who arrived in big numbers rapidly shrank in size and become fragmented, while members of families scattered throughout the continent. Contacts may be maintained between the elements of the families but not as frequent. Although the sense of solidarity is still there, it has less opportunity to manifest itself. This contributes to a progressive blunting of the family spirit, especially among members of the younger generation (Tran in Tu, Cahill and Bertelli, 1989:26).

According to Lien, Klimidas and Minas in Tu, Cahill and Bertelli (1989:92), families suffer from intergenerational conflicts in families, where the younger generation tend to adopt new values more easily than the parents or grandparents. The older generation have no model as how to cope with these new conflicts and often regard the behaviour of the young ones as being disloyal and disobedient to their families. Hence we experience two different sets of customs and values being practiced in the same household, and often, disunity and conflicts arise. As a result, these families have a tendency to suffer from mental stress and illnesses. For example, Hosking (1990:43) observes that the father's role has often been completely stripped as the sole

economic provider and the mother's role as the primary care giver also diminished.

The other issue is with regards to women in their relationships. In these circumstances, many women have entered into marriage unprepared. The marriage might have been arranged, while others married to escape a strict family situation. A few were raped to enforce pregnancy and secure marriage. As a result, many of these women find their husbands insensitive to their needs. There are common issues of poor communication, especially in relation to sexual matters. Because of the expectation of the Vietnamese women in their community to be responsible for family planning, problems arise when an unplanned pregnancy occurs. Some conflicts were resolved by forced abortion (Lien, Klimidas and Minas in Thu, Cahill and Bertelli; 1989: 93).

1.9.3 Other Social Problems

The Vietnamese were also affected by other social challenges as well. In a reported conducted by Visser and Beer (1998:130) on immigrants residing in Western Australia, it was found that the 1996 Census showed that unemployment stood at 19.2 per cent for the Vietnamese compared to 8.1% of the national total. Over 60 per cent of the Vietnamese have an income of less than \$300 per week, compared with 49.3 per cent of the total population. Those in the workforce were concentrated in lower paid occupations with 28 per cent working in the lowest skilled category and 22.8 per cent employed in intermediate skilled occupations.

Finally, in relation to health treatment, there is a reluctance to accept Western medicine, and a preference for Eastern concepts of illness. Notably, the conception of mental health tends to involve the idea that there is a somatic basis, or otherwise, explanations tend to revolve around supernatural causes. For instance, disloyalty to ancestors might be thought to be cause of current misery (Lien, Klimidas and Minas in Thu, Cahill and Bertelli,

1989:93). There are numerous reasons as to why health services are under-utilised by this group, the most notable one being that these services do not cater for the cultural needs of these people (Helman, 1992:45).

It would need more than this study to have an extended insight into the mental health struggles of refugees and how they cope with their new lives. Furnham and Bochner (1986:105), however, argue that in spite of their experiences, they have survived surprisingly well. However, Dr. Tran Minh Tung (a founder member of the Australian Studies of Vietnamese studies) and Dr. On Lien (who is a medical officer at the Victorian Transcultural Unit) feel that the struggle will always be there. The dilemma lies in a desire to hold on to the past and their old image of their self and the world and the necessity to conform to the values and customs of the host country in order to progress (On Lien in Minas and Hayes, 1994:53).

1.10 CONCLUSION

The influx of Vietnamese refugees into Australia between 1975 until 1988 has brought into the limelight questions pertaining to the cultural appropriateness of mental health services set up to service the mental health needs of refugees and immigrants. Statistics have shown that mental illness affects a substantial percentage of the Australian population and this is even more so among Vietnamese refugees who immigrated to this country after prolonged periods of torture and trauma. It is a well known fact that mental health services are under-utilised by Vietnamese refugees, and this has been of concern to mental health practitioners for a long time. It has been widely acknowledged that the underlying fundamental cause has been that mental health services in Australia are rooted in racism, as can be seen in the training of mental health professionals to systems of service delivery. Only by this acknowledgement can the mental health system progress ahead in ensuring the health system continues to look into ways and means of accommodating the cultural needs of the patients. It's structure, planning

and implementation needs to take into account the whole dynamics of the Vietnamese world views for the system to be culturally effective and meaningful. In addition, their experiences of torture and trauma and its associated consequences should make the Vietnamese community one of the main priority groups to be serviced. Their different historical, social and cultural backgrounds should have deep implications for practitioners who are often trained and work under Western systems of operation.

Chapter 2

METHODOLOGY

As outlined in the preceding chapter, the objectives of this study are to:

1. Examine the prevalence of racism within existing mental health services.
2. Analyse existing constructions of culture and mental health/illness.
3. Describe the historical/political experience of the Vietnamese which led to the refugee situation.
4. Examine issues of settlement and the culture of Vietnamese refugees in Australia.
5. Examine and critique barriers of accessibility and issues of cultural appropriateness within existing mental health services from a cross-cultural perspective.
6. Generate recommendations with the intention of eradicating racism and making the mental health system more culturally competent.

The methodology adopted for this study is to present the rationale for the selection of these specific objectives.

This methodology is framed within a social policy analysis which identifies the issues, needs, services and practices in the mental health system. Social policy analysis seeks to analyse writings, structures and practices from the perspective of the 'policy' created or implied in such material and process. It attempts to name how the 'thinking' of the text, practices, reveals, reflects and impacts on policy relating to mental health. This perspective will be examined in the light of the Vietnamese refugees who have settled into the Australian community. This analysis is predominantly represented in text documents from various sources - government documents and reports, academic texts and journals which address the settlement issues facing these Vietnamese refugees and the cultural appropriateness of the mental health system. An examination and analysis of these materials form the mainstay of this study.

2.1 WHY FOCUS ON CONCEPTS OF CULTURE AND MENTAL HEALTH/ILLNESS?

Mental health is influenced by many dimensional components. What these components and how they interact with each other is still not well understood. What we do know, however, is that 'culture' is a critical dimension and therefore needs to be examined. This is done in Chapter 3. The understanding of the concepts of culture and mental health/illness is crucial in helping to make the mental health system more culturally competent. Cross-cultural issues arise in any health setting in Australia. This Chapter highlights the importance of uncovering understandings, beliefs, interpretations in such settings. Fernando (1991:196) argues that in cross-cultural psychiatry, mental health has many meanings. Its maintenance encompasses not only medical factors, but one that has religious, ethical and spiritual dimensions as well. These dimensions are incorporated into the concept of culture. The importance of placing culture in a paramount position in this study can be understood by how Frejos in Spector (1985:50) defines culture:

' the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey, or hand down to the next; in other words, the non-physically inherited traits we possess.'

Culture in this sense, is socially constructed, which encompasses the characteristics that we inherit from the previous generation. It is the luggage that each of us carries around for our lifetime. Spector (1985:50) explains it as:

'the sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals and so forth '

Therefore, for effective and accurate diagnosis and treatment to be undertaken, it is imperative that mental health professionals understand the cultural contexts affecting such decisions. Ridley (1998) in Tilbury (2001) explains that culture

'affects the way people label illness, identify symptoms, seek help, decide whatever someone is normal or abnormal, set expectations for therapists and clients, give themselves personal

meaning, and understand morality and altered states of consciousness.'

The Statement of Rights and Responsibilities forms one of the four important documents under the National Health Strategy formulated and agreed by all State Health Ministers in 1992. The Statement of Rights and Responsibilities seeks to redress the inequities in Australian society and

- recognises the aspirations of all Australian residents to a dignified and secure way of life with equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs;
- is free of prejudice; and
- is caring, just and humane (Mental Health Consumer Outcomes Task Force, 2000:ix).

Under its mandate, one of the consumer rights and responsibilities include the right to have cultural background taken into consideration in the provision of mental health services (Mental Health Consumer Outcomes Task Force, 2000:2). In the section 'Prevention of Mental Health Problems and Mental Disorder', the Statement asserts that individuals have the right to expect culture, gender and age be incorporated in the primary, secondary and tertiary preventative programmes (Mental Health Consumer Outcomes Task Force, 2000:3).

In the clinical situation, Castillo (1997:27) argues that "clinical reality is created within a clinical context by the clinician and the client employing their learned cultural schemas". He explains that there are five ways in which culture affects clinical reality:

- culture-based subjective experience - attitudes, feelings and behaviours which are defined by, and constructed within, a particular cultural framework eg. grief, love, shame, pride and associated behaviours
- culture-based idioms of distress - ways people act to express their illness
- culture-based diagnosis - indigenous practitioner's methods of assessing and diagnosing the problem

- culture-based treatments - appropriate treatment within the cultural meaning system
- culture-based outcomes - outcomes will be based on how the illness has been culturally constructed and treated

Tilbury citing Rollock and Terrell (1996) in Castillo (1997) maintains that culture impacts on the medical arena in these ways. The client's cultural background is the most obvious. However, the mental health professional's cultural background is equally important in influencing the interaction. When both parties derive from different cultural backgrounds, there is a likelihood that the relationship will be potentially problematic. It is essential, therefore, that mental health professionals examine their own attitudes and feelings towards their clients. These interactions serve as part of an interactive interchange that creates and defines the mental illness or wellbeing of the person.

In general, Helman (1992:214) concludes that the relationship of culture to mental illness can be summarised as follows:

- it defines 'normality' and 'abnormality' in a particular society
- it may be part of the aetiology of certain illnesses
- it influences the clinical presentation, and distribution, of mental illness
- it determines the ways that mental illness is recognised, labelled, explained and treated by other members of that society

Similarly, the need to understand concepts of health/illness can also be justified from a cultural perspective. Cross-cultural concepts of illness should also be examined because different cultures define illness differently. According to Fernando (1991:199), many forms of human distress and misbehaviour, although seen from a Western viewpoint as 'illness' are not so in other cultures. In every culture, there are certain phenomena that are defined as problematic and others that are not defined as problematic. An illness model in one culture may not be the same as that in another. Kahn (1986:47) also supports this argument by asserting that abnormal behaviour is largely a matter of deviation from a given culture's socially accepted norms or actions. These norms vary

from culture to culture. Fernando (1991:62) relates the variations in the incidence of diagnosed illness to the social and cultural influences on the construction of illness.

Likewise, the concepts of health also vary widely throughout different cultures. The definitions are based on shared beliefs within a cultural group as to what constitutes the ideal, 'proper' manner in which individuals of that particular group conduct their lives in relation to others. These beliefs provide a series of guidelines on how to be culturally normal and what constitutes health (Helman, 1992:215). Each culture defines which phenomenon it has solutions for and the ways to apply those solutions. In summary, 'what is', how it is understood and how it is responded to is culturally determined. As an illustration, the concept of health in the Western viewpoint is broadly termed as 'active adjustment or mastery of one's environment, the maintenance of a stable integrated personality and the ability to perceive correctly the world and oneself' (Jahoda in Jayasuriya, 1986). In Chinese culture, however, health is understood differently. Spector (1991:172-174) explains that the Chinese view health as a state of spiritual and physical harmony with nature. Illness is the disharmony of Yin and Yang and this disharmony leads to pathological changes. When Yin and Yang are sound, the person is living in peaceful and proper interaction with his mind and body. Health, therefore, has to be understood in the right cultural context.

The values and customs associated with illness form part of the wider culture and cannot really be studied in isolation from it. We cannot truly claim to understand how people respond to illness without an understanding of their cultural background.

2.2 WHO ARE THE VIETNAMESE AUSTRALIANS?

The broad aim of Chapter 4 is to gain an insight and understanding of the Vietnamese cultural, social, historical and political background. To do this, four specific sub-headings are used:

- the historical and political background which led to the refugee exodus
- social issues associated with the refugee settlement
- the Vietnamese cultural self
- health-seeking behaviour amongst the Vietnamese

The Vietnamese community is chosen because they form one of the most disadvantaged immigrant groups to resettle into Australia as refugees. The refugee experience, which left many tortured and traumatised, and the different cultural background, as compared to the Australian mainstream Anglo-Saxon culture, has made settlement difficult (Thomas, 1999). Krupinski (Jayasuriya, Sang and Fielding, 1992:25) identifies the Indochinese refugees as one of the four groups of immigrants who are considered as 'high risk'. McGorry (Jayasuriya, Sang and Fielding, 1992:28) sums up his discussion on the sequelae of torture in these words:

'Victims of torture are faced with a major task of social adaptation they are usually unable to easily obtain the specific medical and psychiatric care, and social and resettlement support that they urgently need. This stems from the lack of specific services and sensitive to the needs and fears of survivors of torture.'

The importance of understanding the client's background is emphasised in the Report of the National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission, 1993:746). The Inquiry was told that there is a critical need for professional education of psychiatrists and other mental health professionals in cross-cultural issues. Several expert witnesses claim that cross-cultural awareness is often treated superficially by medical professionals. This lack of commitment has to be addressed to ensure that services delivered are culturally appropriate.

'I want to make a special point about education. Education particularly regarding ethnic services (is often reduced to) folkloristic (stereotypes) The Italians like spaghetti and the Chinese are afraid of spirits Education has to be meaningful (not only) at the level of services but as part of

the university curricula for people who work in the field of mental health, be those people social workers, sociologists or doctors . . . We cannot go off and claim that we have met our responsibilities regarding the education of people with a couple of lectures on how (a particular ethnic group) behaves or a couple of lectures on migrants and mental health.'

Other evidence to the Inquiry also supports these observations. Consumer organisations stress the crucial need for the provision of continuing education for government and non-government mental health workers as essential. Non-medical staff working in ethno-specific agencies should also be included in this training. This is seen as a simple and effective way of reducing inappropriate referrals (Human Rights and Equal opportunity Commission, 1993:747).

Besides government legislation, professional guidelines also call for the practice of culturally appropriate and sensitive care. For instance, the Charter for Clients of Psychologists drawn up by the Australian Psychological Society states that 'you will be shown respect for your cultural background and language tradition' (Australian Psychological Society in Tilbury 2001).

There have been numerous studies by experts in the area of mental health who have endorsed the importance of understanding the client's cultural, social, historical and political background to ensure that treatment can be more culturally meaningful and effective. An example of such a study is by Minas, Lambert, Kostov and Boranga (1996:98). According to them, the most essential resource of the mental health system is the cultural competence skills of its staff. They assert that, apart from the staff having the need to be aware of their own cultural values and heritage, it is crucially important that they are also knowledgeable about the cultural beliefs and practices of their clients.

The understanding and knowledge of the client's background is clearly apparent if mental health professionals are committed to ensuring that their service delivery result in successful outcomes.

2.3 WHERE ARE THE BARRIERS?

Chapter 5 seeks to examine and critique barriers of accessibility within existing mental health services from a cross-cultural perspective. The significance of examining these limitations can be understood by what Stavenhagen (1993:59) says about oppression structures. He argues that the causes of oppressing, exploitation or deprivation are to be found in the functioning of total systems and in the nature of the relationships binding the oppressed and the oppressor. Within this argument, it is evident that studies should not only be about the oppressed, but more importantly, about the oppressor or dominant groups. The understanding of social forces in the process of social change requires not only knowledge of the so-called underprivileged groups, but of the system of domination as well. It requires an understanding of the mechanisms where the elite social groups fit into the general structure, how they react to, and participate in, the process of change and how they maintain, adapt or modify existing systems.

Reid and Trompf (1990:377) argue that the dominance of the health-care system by the medical world has led to the achievements of ethnic health care being marginalised. Ethnic policy advocates must, therefore, review the failures so that changes in the mainstream health system can be effected.

The rationale for an examination and critique of barriers of accessibility from a cross-cultural perspective can also be justified by a list of nine significant deficiencies observed by Minas, Silove and Kunst (1993:5) in a report of a consultancy commissioned by the Commonwealth Department of Human Services and Health:

- ❖ inadequate mental health legislation and failure to implement existing policies
- ❖ poor quality of service currently available to CALD communities
- ❖ lack of involvement of members of CALD communities in the design and evaluation of services
- ❖ inadequate access by CALD communities to information

- ✱ failure to adequately study stigma and to develop approaches for its diminution
- ✱ inadequate education of mental health professionals
- ✱ inadequate research
- ✱ inadequate information about mental health status and mental health service needs of CALD communities
- ✱ inadequate information about patterns of service utilisation by CALD communities

In another equally important report - the Report of the National Inquiry into the Human Rights of People with Mental Illness - the findings also clearly indicate the need to examine additional weaknesses within the existing system:

- ✱ mainstream services are not meeting the needs of large numbers of people from CALD communities
- ✱ people from CALD communities often come into contact with the health system only when their illness has reached the acute stage
- ✱ there is a clear need for transcultural mental health services and specialist programmes for individuals with particular needs, such as survivors of torture and trauma
- ✱ interpreters are both under-used and used inappropriately
- ✱ there is a dearth of information about the rates of mental illness among different ethnic communities (Human Rights and Equal Opportunity Commission, 1993:939).

2.4 A WAY FORWARD - WHAT DO WE NEED TO PAY ATTENTION TO?

Chapter 6 is a natural progression from its preceding chapter. It seeks to generate discussion and recommendations with the intention of eradicating racism and making the mental health system culturally competent. Stavenhagen (1993:61) argues that while the accumulation of knowledge is an element of power, it does not necessarily always serve to maintain existing power structures. On the contrary, it may, *and must, become an instrument for change*. This should be done through the awakening and development of a creative critical conscience and

enables the powerless, the oppressed, the downtrodden and the colonised to question and finally to modify existing systems.

The importance of this Chapter is evident by the reports that have emerged in making recommendations to address the failings of the mental health system in the provision of effective service delivery to members of CALD communities. One example is the Report of the National Inquiry into the Human Rights of People with Mental Illness:

- State and Territory governments should establish transcultural mental health services and, as appropriate, specialist programmes in each capital city
- States and Territories should take cultural issues into account in their mental health policies, programme planning and service delivery. The employment of multilingual staff and staff with training in cross-cultural issues should be encouraged
- general practitioners, psychiatrists, nurses and mental health workers should receive appropriate training in cross-cultural issues (especially in terms of symptomatology, diagnosis and assessment)
- the composition of mental health review and guardianship bodies should reflect the multicultural nature of our society (Human Rights and Equal Opportunity Commission, 1993:939).

The response from the government with regard to the recommendations proposed by this Inquiry places further importance on this issue. In a Federal Government Discussion Paper (Commonwealth of Australia, 1994:21) the Federal Government agrees that:

'. . . . the providers of mental health services should be responsive to the particular needs of different groups, and that adequate resources should be made available to these groups. Because the needs of special groups are likely to vary between communities over time, the government believes it should be the responsibility of those planning and allocating resources within an area or a region to assess priorities for resource allocation, taking into account the level of need and the range of existing services.'

The government also specially proposes that the recommendation of a workshop and consultancy funded under the National Mental Health

Strategy to look into the mental health needs of people from CALD communities be considered (Commonwealth of Australia, 1994:22).

According to Minas, Stuart and Klimidis (1994) and Singh (1994) in Minas, Lambert, Kostov and Boranga (1996:145), a majority of staff currently working in psychiatric services believe that their professional training has not adequately provided them with sufficient knowledge or understanding of cultural issues to adequately address and treat people from a different cultural background. They affirm that this has negative consequences in terms of treatment outcomes for members of CALD communities.

Apart from the Report of the National Inquiry into the Human Rights of People with Mental Illness undertaken by the Human Rights and Equal Opportunity Commission (1993) three notable documents under the National Mental Health Strategy also calls for mental health service delivery models to be culturally appropriate:

The National Mental Health Policy

The provision of services that are appropriate to the needs of CALD communities is endorsed as a fundamental right in this Policy. It explicitly recognises that there are groups in the community with special needs, stating that:

'Mental health service systems should be responsive to the varying needs of particular groups. In some cases, these groups will require specific services within the mental health system. It is important that mental health services be planned and delivered in a manner which is sensitive to the needs and expectations of different groups in the community' (Minas, Lambert, Kostov and Boranga, 1996:74).

The Statement of Rights and Responsibilities

Apart from other rights, it also states that consumers have the right to have their cultural background and gender taken into consideration in the provision of mental health services. As far as access is concerned, it recognises that people with mental health problems or mental disorders should have access to services and opportunities available in Australian

society. Apart from other access, it states that access to, and availability of appropriate services requires consideration of specific needs and ideally is not limited by cultural and ethnic barriers (Mental health Consumer Outcomes Task Force, 2000).

The National Mental Health Plan

It states that:

‘Within the life of the Plan the States/Territories, will report on the development of the most appropriate service models to meet the service requirements of identified special needs groups across different regions’ (Minas, Lambert, Kostov and Boranga, 1996:74).

2.5 LIMITATIONS OF THE STUDY

The objectives of this study are to:

1. Examine the prevalence of racism within existing mental health services.
2. Analyse existing constructions of culture and mental health/illness from a cross-cultural perspective.
3. Describe the historical/political experience of the Vietnamese which led to the refugee situation.
4. Examine issues of settlement and the culture of Vietnamese refugees in Australia.
5. Examine and critique barriers of accessibility and issues of cultural appropriateness within existing mental health services from a cross-cultural perspective.
6. Generate recommendations with the intention of eradicating racism and making existing mental health services more culturally competent.

The scope of this study in Objective One does not extend to the discussion of concept of ethnicity in detail. Although this would seem to be a natural inclusion in the discussion of the concept of culture, the main argument of this study is about the cultural competence of the mental health system. Ethnicity is only superficially discussed as a distinction between the two concepts.

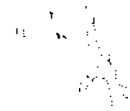
The historical/political experience of the Vietnamese which led to the refugee situation is traced back to events which led to the civil war between North and South Vietnam in 1975. Chinese domination from 111BC is only briefly touched on to indicate its influence for the next 1000 years. This section starts with the capture of Vietnam by the French in 1884. This period is the most important cause of the refugee exodus. Social issues relating to the refugee settlement are limited to discussions of language difficulties, unemployment, accommodation, family life and settlement. These issues, according to the literature, form some of the main concerns relating to settlement.

There are many barriers of accessibility within the mental health system. Inadequacies, according to Minas, Silove and Kunst (1996:5) include the

- mental health legislation and failure to implement it properly;
- lack of involvement of members of CALD communities in the design and evaluation of services;
- failure to adequately study stigma and to develop approaches to minimise the problem;
- lack of education for mental health professionals;
- lack of research;
- poor quality of services;
- lack of adequate information about mental health service status and mental health needs of CALD communities; and
- inadequate information about patterns of service utilisation by CALD communities.

For the purpose of this study, however, the focus will be on the existing mental health legislation and cultural and linguistic barriers. Cultural barriers will be examined in the light of diagnostic tools used, issues of cross-cultural counselling and communication as well as problems associated with the use of interpreters. The scope of this study does not allow the researcher to do justice or discuss all the deficiencies that can be found in the mental health system. To do so in a brief manner would undermine the importance of each of these deficiencies.

Approaches to eliminate some of these barriers include the issue of how to combat racism within the existing mental health system, and how mental health professionals can be more culturally competent. It does not attempt to address the promotion of mental health services, future research, involvement of members of CALD communities in its planning and evaluation, future research and issue of stigma. Each and every one of these factors significantly contribute to weaknesses within the mental health system and deserve a thorough examination. It is not possible to do so within the confines of this study.



Chapter 3

THEORETICAL FRAMEWORK

3.1 INTRODUCTION

Culture and health are closely interwoven and any aspects of illness, in particular mental illness, can no longer be justifiably explained from a purely medical perspective. Transcultural psychiatry, (which has also been known by a number of different names, including cross-cultural psychiatry, comparative psychiatry or simply cultural psychiatry) focuses on the role of culture in the development and treatment of mental illness. It focuses on how culture influences the manner in which the problem is perceived to have been caused, manifested and treated. If this context is ignored, Minas (Reid and Trompf, 1990:22) cautions that mental illness, regardless of whether it has a biological basis or not, will not be sufficiently understood. The issue is how mental illness is experienced and expressed within a socio-cultural context.

Minas (Reid and Trompf, 1990:20) states that there has been an increasing awareness that the dominant scientific approach, which is based on a Cartesian reductionist epistemology, is no longer considered as the only appropriate means of understanding or treating mental illness. There is a need to shift to a more systematic ecological awareness such as maintained by Minas (Reid and Trompf, 1990:20):

'Systems, sub-systems and context are closely connected in a complex web of inter-relationships and notions of linear causality are a gross over-simplification. De-constructing reality and studying the parts does not lead to an adequate understanding of the whole'.

In order to accommodate this shift towards a more cultural and holistic approach to treating mental illness, it is necessary that concepts of culture, cultural self and health, in particular mental health/illness, be examined in order to place this research in a particular conceptual framework. They form the keywords to a better understanding of this research as well as addressing one of the objectives of this paper; that is,

to critique existing constructions of culture and mental health/illness from a cultural perspective.

This chapter is divided into the following headings for discussions:

1. Concepts of Culture: Theoretical approaches to cultural studies is also included to give an insight into how 'culture' is studied.
2. Concepts of Mental Health/Illness: In addition, the changing views of mental illness in the modern world are also included.
3. A Comparison of the different Understandings of Mental Health/Illness between Eastern and Western Cultures: This section also discusses the influence of Chinese culture on Vietnamese concept of health/illness.

3.2 CONCEPTS OF CULTURE

According to Brislin (1984:5), there are many abstract definitions of culture, and most of them suggested by anthropologists. Two most commonly cited in the area of cross-cultural research belong to Kroeber and Kluckholm (1952) and Triandis (1972). After reviewing more than 150 definitions, Kroeber and Kluckholm conclude that the following are central ideas adopted by most social scientists:

'Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artefacts; the traditional core of culture consists of traditions (ie., historically derived and selected) ideas and especially their attached value; cultural systems, may on the one hand, be considered as products of action, on the other as conditioning elements of further action'.

Fejos in Spector (1991:50) describes culture as 'the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey, or hand down to the next; in other words, the non-physically inherited traits we possess'.

The definitions of the term 'culture' for research purposes has given rise to much theorising about culture. Fernando (1991:9) explains that originally it was seen as 'something out there', a social concept, but

recent theorists have attributed it more to something 'inside' a person – a psychological state. To further expand on this psychological perspective, Fernando (1991:10) quotes Leighton and Hughes (1961) in defining culture as 'shared patterns of belief, feeling and adaptation which people carry in their minds' and Linton (1956) as 'an organised group of ideas, habits and conditioned responses shared by members of a society'. Benedict (1965) in Fernando (1991:10) defines it as 'a more or less consistent pattern of thought and action, governed by its own characteristic purposes'. Each person progressively consolidates their experiences so that the most ill-assorted traits accumulated by them during their lifetimes become characteristic of their cultural goals.

From these definitions, it can be seen that culture could be expressed as a set of guidelines (both explicit and implicit) which individuals inherit as members of a specific society. It tells individuals how to view the world, how to experience it emotionally and how to behave in relation to other people, to supernatural forces or gods and lastly, to the natural environment. In addition, it also provides individuals with a way of transmitting these guidelines to the next generation through the use of symbols, language, art and ritual (Helman, 1992:3).

From this discussion, people are seen to be culturally similar if they share similar beliefs and preferences. Green (1995:14) however, argues that this approach has its limitations. In his view, a theory that places stress mainly on values propositions and hence suggests that any individual's identity is essentially the match between that person and a given set of values, is close to the kind of stereotyping which could leave out important dimensions of culture. Examples of these dimensions include power and powerlessness, situational expressions of ethnic loyalties and how these play out in interactions between persons of differing and perhaps hostile communities. These issues become important as people in many parts of the world have come to live with and interact closely with people of other cultures. These dynamics become part of people's everyday lives and in some cases, play a dominant role where its impact may be drastic.

Tilbury (2001:5) cites Carrilo (1999) in warning that any attempt to raise levels of cultural awareness could run into the risk of stereotyping those from different ethnic groups. It is important to bear in mind that individuals are not cardboard cutouts, stereotypic simplification of the main aspects of their cultural backgrounds. Within any culture, individuals may adopt values, attitudes, beliefs and behaviours which are idiosyncratic or unusual from the perspective of their cultural backgrounds.

Green (1995:14) further elaborates on this view and argues that the word 'culture' has to be given more precise meaning before it can be used as an analytical tool. We need to discuss it in terms of differences or contrasts. Someone else's culture is most evident when one contrasts what one sees in that person with what one knows about oneself. In other words, culture is relative when compared to another's. The presence of 'another' makes one self-conscious of one's own cultural distinctiveness. When confronted with someone perceived as different, that person's 'culture' might be any number of things, eg., religion, family life, values etc. In this mutual presentation of 'self', Green (1995: 14) believes that what passes as 'culture' is usually brief and very specific and a little bit more than a glimpse of that entire one is as an individual. 'Culture' then, in this sense is not something the other 'has', such as a specific value or physical appearances. It is rather the perspective that guides our behaviour, however brief the encounter. Seen from this angle, culture is not an essential or innate property of a person, but rather, the meanings that two people act on in a specific relationship.

When discussing the concept of culture, it is important that the terms 'ethnicity' and 'race' are also considered. This is because, according to Fernando (1991:22), they are interrelated in complex ways, depending on historical, political and social factors. Culture is often confused with race both in the public and in the professional arena, mainly because people who are seen as racially different are conceptualised as having different cultures. The concept of ethnicity in social science literature and in popular thinking has replaced, to some degree, both culture and race as

the basis for defining meaningful groups of people who feel themselves to be separate in multicultural societies. The term 'ethnicity' has both racial and cultural connotations, but its main characteristic is that it implies a sense of belonging. Ethnicity, then, may emerge in a society through pressures and alliances arising from cultural similarities, racial discrimination or other forces that induce people to feel a sense of belonging to an 'ethnic' group.

According to Spector (1991:51), cultural background is a fundamental component of one's ethnic background. The term 'ethnic' has for some time aroused strong negative feelings and is often rejected by the general population. This stance originates from the fact that most foreign groups who immigrated to Australia often had to shed their old ways in an attempt to assimilate themselves into the mainstream culture. These changes in behaviour usually occur in response to people's needs to find a way to function in a new country. Many cultural groups may cluster together against the majority who may be discriminating against them.

Although the terms 'race', 'culture' and 'ethnicity' are interrelated, Fernando (1991:23) cautions that they should be distinguished from each other. In general, the term to be used depends on the style and degree of racism in the society at the time, the extent to which people in power appreciate the situation and the particular purpose for which the classification is required. Sensitivity and awareness of all aspects of the particular context in which it is used should govern the choice of label.

Helman (1992:4), however, warns of too many generalisations in explaining people's beliefs and behaviours. He argues that the concept of culture has sometimes been misunderstood by users of this term. Cultures are never homogeneous and members of any given group have just as much differences as those belonging to members of different cultural groups. One should therefore try to differentiate between the rules of a culture which govern how one should behave and how people actually behave in real life. Generalisations often lead to the development of stereotypes which may result in cultural misunderstandings, prejudices

and at its worst, discrimination. In the context of medical care, too many generalisations could lead to misinterpretations of how people present their symptoms. Symptoms or behaviour may be ascribed to the person's culture, when they are really due to an underlying physical or mental disorder. Another reason is that cultures are never static as they are usually influenced by other human groups around them. In most parts of the world, they are in a constant process of adaptation and change. The society in which we live and other external forces, for example, political, economic and social forces, tend to alter the way in which some of the aspects of a particular culture are transmitted and maintained.

An important point to note also is that culture must always be seen in its particular context. This context is made up of historical, economic, social, political and geographical elements. This means that the culture of any group of people, at any particular point in time, is always influenced by many other factors. Seen in this context, it may therefore be impossible to isolate 'pure' cultural beliefs and behaviour from the social and economic context in which they occur. (Helman, 1992: 5). This is specially so when dealing with people who are dislocated from their country of origin.

3.2.1 Theoretical Approaches to Cultural Studies

According to Barnett and Silverman (1979) in Meemeduma (1987:36), there are three major theoretical approaches to the study of other cultural groups, and these are the universalist approach, the evolutionist approach and the relativist approach. All three approaches attempt to examine the contradictions of sameness and difference in the interpretation of social reality. They also provide an understanding of the different stands researchers take on cultural issues.

The universalist approach is more interested in the concept of the universality of the human condition and frequently emphasises general likeness rather than specific differences. Cultural diversity then is more apparent than real (Shweder and Bourne 1984, in Meemeduma, 1987:36). From the discussions of culture in the

preceding section, it can be seen that this approach does not sit well with modern day sociologists. Its emphasis on sameness differs from what Green (1995:14) propounds, and that is, culture needs to be discussed in terms of differences or contrasts in order for one to be aware of one's own cultural distinctiveness.

The evolutionists, on the other hand, view other cultural systems as truly different. These differences, however, are seen as reflective of a less developed and at an inferior stage of the cultural evolutionary process the other cultural group is presently at. The idea is to 'map' the evolutionary upgrading of cultural groups through their contact with 'higher stage cultures' (Meemeduma, 1987:37). There has been an acknowledgement among social scientists that social sciences are embedded in colonialism and imperialism. This evolutionist theory of studying cultures reflects the typical colonialistic and imperialistic attitudes of some white, Western sociologists who study minority ethnic groups (Stavenhagen, 1993:52). Howard and Scott (1981) in Meemeduma (1987:37) argue that this approach has taken on a particular deficiency formulation because the people belonging to the culture in question are assumed to be inferior compared to the researchers. Not only that, the indigenous cultural symbols, skills, knowledge and institutions belonging to the culture are seen as impeding the adaptation of the minority group in the host society.

The last approach adapted by most researchers of cultural groups is the relative approach. Relativists believe that other cultures are not only 'fundamentally different to our own but also have an internal coherence, logic and value, which can be described and understood through research but not judged' (Shweder and Bourne, 1984 in Meemeduma, 1987:38).

However, even this approach has its limitations. According to Rahman (1991:14), there is very little or no research on any

aspects of social science that can claim to be completely free from bias:

'Any observation, whether it is detached or involved, is value biased.'

Stringer (1996:146) also asserts that cultural studies have their own limitations because social reality is difficult to measure as it exists as:

'an unstable and dynamic construction that is fabricated, maintained and modified by people in the course of their ongoing interaction with each other and their environment. It operates according to systems of meanings embedded in each cultural context and can be understood only superficially without reference to those meanings.'

Stringer (1996:14) argues that truth is relative and that "knowledge cannot be judged as an objective set of testable truths because it is produced by processes that are inherently captured by features of the social world it seeks to explain".

The relativist, however, argues that the 'subjective' experiences of any cultural group does have some inherent worth and therefore, should be valued as the source of knowledge and understanding in any research (Meemeduma, 1987:38).

It is important to understand the position social scientists take in doing research so that they are aware of their personal and cultural limitations and biases. In the context of this research, a relativist approach was found to be used by most of the authors as it appears to be less patronising and more appreciative and accepting of differences.

3.3 CONCEPTS OF MENTAL HEALTH/ILLNESS

Mental health and mental illnesses have always been contested issues and therefore, are inherently problematic notions. As a result, definitions of these terms are often debated, and even more so within the area of multiculturalism. What mainstream Australian society tends to refer to as 'mental illness' in the last decade of the 20th century has not always been, and is not universally regarded as a medical matter. Likewise, the tendency to dichotomise between mental, physical and spiritual concerns is not, and has not always been shared by other societies (Human Rights and Equal Opportunity Commission, 1993:38). Every immigrant group brings cultural attitudes towards health, health care and illness. Within each of these groups, widely varying health and illness beliefs and practices exist. According to Spector (1985:59), health and illness can be interpreted and explained in terms of personal and cultural experience and expectations. There are many ways in which we define our own health or illness and determine what these states mean to us in our everyday lives. We are conditioned in our own cultural and ethnic backgrounds how to be healthy, how to recognise illness and how to be ill.

According to Parsons (Reid and Trompf, 1990:110) however, the understanding of health and illness depends on the person's conception of the body-mind relationship. Body, mind, emotions, spirituality and views of the cosmic order may all influence the way a person responds to any one illness episode. Beliefs about the body-mind relationship affect the way people experience this world, their harmony and disharmony with their social and natural environment. Such beliefs influence their comprehension of medical diagnosis, their cooperation in prescribed therapies and their satisfaction with the results of health and illness interventions.

3.3.1 Mental Health - A Further Discussion of its Concepts

The meanings attached to the notions of health are related to the basic culture bound values by which we define a given experience and perception. As White in Fernando (1991:2) aptly puts it:

“The notion of ‘mental health’ derives from a particular tradition of medical research and practice which does not provide a neutral stance from which to analyse or represent the way ‘other cultures’ conceptualise disorders of the person and social behaviour. To begin with, the boundary between disorders of the mind ((the province of psychiatry and neurology) and of the body (the province of internal medicine) is itself a cultural construction which underlies the segmentation of a class of illness we refer to as ‘mental.’”

The term ‘mental health’ as Murphy (1982) observes, shares much with the notion of the ‘quality of life’. However, it is often expressed so vaguely and ambiguously that it is difficult to define it conceptually. The more positive conception of ‘mental health’ other than in the conventional sense as the absence of ‘illness’ remains elusive, fuzzy and extremely difficult to define (Jayasuriya, Sang and Fielding, 1990:2).

A workable point of view, however, which has gained some popularity, is Marie Jahoda's three criteria for determining mental health and that is, ‘active adjustment or mastery of one's environment, the maintenance of a stable integrated personality, and the ability to perceive correctly the world and oneself’ (Jayasuriya, 1986).

Most of the contemporary literature on mental health refers to Jahoda's definitional pioneering work in 1958. This work suggests that positive mental health is based on the following specific major categories of concepts:

1. attitudes of an individual towards his/her own self
2. growth, development or self-actualisation
3. personality integration
4. autonomy

5. perception of reality and
6. environmental mastery (Mendelson in Minas and Hayes, 1994:2)

According to Jahoda, all ideas of positive mental health can be assigned to one of the above six categories. A mentally healthy attitude towards the self is explained by her in terms of self-acceptance, self-confidence and self-reliance. These terms imply that the individual has learned to accept both the limitations and possibilities one may find in oneself and that one has formed the judgement that in balance, one is 'good', 'capable' and 'strong'. The individual also has a sense of independence from others and of initiative from within (Mendelson, 1994:7).

The Canadian Task Force in 1988 developed a more 'interactive' definition of mental health, outlining that:

'Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities (cognitive, affective and relational), the achievement of individual and collective goals consistent with justice and the attainment preservation of conditions of fundamental equality' (Jayasuriya, Sang and Fielding, 1990:2).

This definition has been recommended as the definition for adoption in the Australian public health policy and it correlates well with the everyday notion shared by psychiatrists that "mental health is characterised by integrity in thought, feeling and behaviour, all governed from some centrally unifying and predominantly conscious 'self', and mental illness by the breakdown of this integrity, of the unified rationality characterising 'normal' human behaviour" (Banton et al, 1985:62).

3.3.2 Changing Views of Mental Illness in the Western World

The changing views of mental illness in Western societies are illustrated in the Report of the National Inquiry into the Human Rights of People with Mental Illness (1993:38-46). A brief

discussion of these views brings to light that even in the Western world, there has never been one view that has endured over the years.

According to this Report, in ancient Greece, abnormalities of the mind were due to natural causes in exactly the same way as other forms of disease. Supernatural explanations were not uncommon within the spread of Christianity. However, natural causes were lost sight of and madness was seen as a manifestation of possession by the devil or other evil spirits; heresy or other forms of immorality. This theological model which involved exorcism rather than treatment was used to justify punitive measures against those displaying 'mental disturbance' and systematic persecution of those labelled as witches. A century later, emerging trends to regard such people as ill and to treat them with sympathy and medical care were still, however, condemned by King James VI of Scotland in a treatise called 'Daemonologie'. Mental illness was not seen as deserving of human compassion and understanding (Human Rights and Equal Opportunity Commission, 1993:39).

The 'medical model' did not emerge quickly. During the 'Enlightenment' period in Europe, the prevailing concept of madness moved from that of supernatural disorder to one of a natural condition akin to bestiality. These 'dangerous lunatics' as they were commonly referred to, were put in confinement as if they were wild animals. Systematic neglect and abuse of people was common and this situation was beginning to be perceived as requiring redress (Human Rights and Equal Opportunity Commission, 1993:39).

By the 19th century, the acceptance of mental disorder as a 'natural' phenomenon led to the study of psychology and other various approaches to clinical treatment of mental health conditions. There was an increasing willingness to acknowledge

that 'mental illness' may be part of the dynamics of the human condition in the same way physical illness was, and that it did not represent an evil manifestation. The science of psychiatry was by then well established embracing many differing views about cause and treatment, although most believed that medical illness was a medical phenomenon. The first half of the 20th century witnessed the expansion of psychoanalytic and other psychotherapeutic approaches to mental illness. In spite of differences in approach, psychiatrists, however, have established themselves as the recognised experts in handling mental disorders. A degree of standardisation in the classification and diagnosis of mental conditions began to emerge (Human Rights and Equal Opportunity Commission, 1993:39).

In the second half of the 20th century, the medical model was reinforced by progress made in research on the physiology of mental illness. The developments made in the aetiology, therapy and management of mental illness was due to refinements in genetics, biochemistry and neurophysiology, especially with regards to the understanding of abnormalities in the transmission of electrical impulses in the brain (Human Rights and Equal Opportunity Commission, 1993:39).

Understanding the historically changing views of mental illness lends weight to the cross-cultural conceptions of mental illness/disorder. This is because it has shown that even in the Western world itself, there has been different views of mental illness, in how it should be seen, diagnosed and treated over the last few centuries. The implication for Western trained practitioners is that there is not one definitive view of mental illness that can claim to be more accurate than others, or accepted and unchallenged by the medical world.

3.3.3 Mental Illness - A Further Discussion of its Current Concepts

Presently, the concept of mental illness is just as problematic and controversial as it was during the earlier ages. Even the problem of defining mental illness for legal purposes has been approached differently in the various States and Territories of Australia. In most cases, however, legal practitioners tend to leave defining the term to medical practitioners who hold the effective decision-making power under the legislation. Many legislative formulations are a little more than token gestures and are almost left entirely to the opinions of psychiatrists (Human Rights and Equal Opportunity Commission, 1993:40).

In its most general sense, it refers to a condition in the individual in which their functioning is felt by them, or by others to be impaired. As a parallel with mental health, the implicit value connotations and prescriptive character of the impairment raise questions about what is considered undesirable and unacceptable behaviour. Discussions about the concept of mental illness by psychiatrists in the 1960s (for example, Thomas Szaz, Ronald Leifer and David Cooper) have been vigorous, varied and controversial (Clare, 1980). The increasing dominance of the medical model of mental illness has been challenged in recent years by sociologists, psychologists, social workers, counsellors and others critical of the role of psychiatrists. They believe that what psychiatrists regard as symptoms of mental illness should be taken as behaviour deviating from social norms. Although not necessarily denying organic causes of mental disorder, they focus attention on the social effects of disordered perception and behaviour.

The psycho-sociological approach has also given rise to the educational model of mental illness or disorder. This educational model believes that the cause of the illness or disorder is the result of defective or ineffective learning and the developmental stages of social interaction is often examined. The most practical application of the educational model is in the sphere of

rehabilitation where emphasis is more on learning or relearning patterns of normal behaviour than on the 'cure'. This model has the advantage of reducing stigma (Human Rights and Equal Opportunity Commission, 1993:39-40).

The sociological model has emphasised the role of the wider social context in creating meaningful experiences for the person with mental illness. The critical psychiatry approach rejects a medical model, and tends to assert that the standards by which patients are defined as mentally ill are psycho-social, ethical and legal and not medical. They tend to treat psychiatric illness not so much as a disease, particularly within the family, but as a social construction reflecting the specific socio-cultural context of behaviour at a given time (Jayasuriya, Sang and Fielding, 1990: 3).

The critics of orthodox psychiatric thinking maintain that although specific disorders of thinking and behaviour result from brain dysfunction, it is more appropriate to say that people who are labelled 'mentally sick' suffer from a disease of the brain rather than to assert that all of those who are considered mentally ill are 'sick' in the medical sense. This implies strongly that psychological disorders regarded as mental illness comprise a wide range of severity and complexity, both as regards their underlying causes and subsequent treatment. Szaz, R.D. Lang and others in the anti-psychiatry' camp however, criticise this concept and warn that this can lead to unfortunate consequences for those diagnosed as mentally ill, even to the extent of depriving patients of their civil liberties through involuntary hospitalisation and other coercive techniques (Jayasuriya, Sang and Fielding, 1990: 3).

In general, however, the excessive claims of the anti-psychiatry movement have been rejected, and this has resulted in a more realistic and defensible view of the nature of mental illness

(Ingleby 1981, Sedgwick 1982). This view is typical of one that Jayasuriya summarises as:

'mental illness' refers primarily to gross, detectable abnormalities of functioning with or without an organic substratum, as well as those 'functional disorders'. The latter are said to be 'refractory to all procedures of understanding and empathy' and incapacitate one from performing critical roles such as earning a living'. (Jayasuriya, Sang and Fielding, 1990: 4).

A more comprehensive and widely accepted psychiatric classification system is that developed by the American Psychiatric Association's 'Diagnostic and Statistical Manual of Mental Disorders'. This system involves vigorous applications of operational criteria and is designed to produce a high level of consistency in psychiatric diagnosis. It states that:

'In DSM-111-R each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, eg. the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the person. Neither deviant behaviour, eg. political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person'(Human Rights and Equal Opportunity Commission, 1993:47).

By including the cultural psycho-social, legal and ethical factors within the concept of mental illness, it assists in treating psychiatric illness not so much as a medical problem, but as a consequence of the psychological and social influence that has impacted on the

client. It embraces a more holistic viewpoint as well as respecting the cultural world from which the client has grown up in.

3.4 DIFFERENT UNDERSTANDINGS OF MENTAL HEALTH AND ILLNESS BETWEEN WESTERN AND EASTERN CULTURES - A COMPARISON

This section aims to discuss common Western and Eastern (Vietnamese) understandings of mental health/illness. This should prove useful in expanding the understanding of traditional mental health/illness concepts of the Vietnamese for Western - trained practitioners.

According to Fernando (1991:77), although the concept of health is usually related to the concept of illness and vice-versa in most cultures, the medical model of illness that has developed in Western cultures studies the mind as distinct from the body. This is done by defining 'mental illness' and promotes psychiatry as a medical speciality. It is claimed that the causes of mental illness are free from religious, ethical and spiritual aspects of the culture. The fundamental belief that underpins the illness model is what Ryle (1949) calls the official doctrine derived from the theories of Descartes – the dogma of the ghost of the machine.

The theory maintains that there exists both bodies and minds; that there occurs physical processes and mental processes, that there are mechanical causes of corporal movements and mental causes of corporal movements. In separating mind from matter, Descartes enables scientists, rightly or wrongly, to study matter without reference to themselves as human beings. There emerges the view of mind as an objective 'thing' to be studied by objectified methods. Scientists, encouraged by their successes to treat living organisms as machines, tend to believe that they are nothing but machines. It is this scientific viewpoint that still dominates Western thinking and it is this worldview that is often in conflict with the worldview of people belonging to other cultures. By imposing such a worldview (and hence its related diagnosis and treatment), Fernando (1991:78) argues that the infiltration of such an

attitude has obstructed mental health agencies in providing culturally appropriate care and treatment.

Williams (Radley, 1993:71) explains the reasons why there has been a silence on the subject of religion in medical sociology in the Western culture. Although it is beginning to emerge, it is not difficult to understand the reasons for the non-inclusion. The rise of sociology in the 1960's occurred during a period of steep decline in churchgoing. The university culture during this period was antagonistic towards religion. Sociology, in particular, tended to treat religion as an epiphenomenon. The sociology of religion was dominated by the topic of secularisation whereas the sociology of illness was under the influence of medicine. Where illness was not dominated by medicine, it was dominated by a monolithic picture of society in which social conventions defined what is normal. The sick were considered as deviants who struggled with and renegotiated, accepted, evaded or cheated these norms.

Lewis-Fernandez and Kleinman (1994) in Minas, Lambert, Kostov and Boranga (1996:83-84) outline three fundamental, culturally derived assumptions of Western psychiatry:

- 📌 The Egocentric Self: Self is understood as a self-contained autonomous entity. This implies that psychological normality and abnormality are internal to the self, de-emphasising the social origins and the social course of mental illness. However, most of the world's population and a substantial percentage of Australia's immigrant population, leans more to a sociocentric conception of self. This means that individuals are embedded more in networks of social relationships from which self-worth, self-fulfilment and self-control, and other attributes are drawn. Reciprocal interpersonal rights and obligations are more important than individual rights.

- 📌 Body-mind Idealism: As explained by Fernando (1991:78), events arise either in the brain or in the mind, with the former having a greater

reality. This leads to a division of psycho pathology into two broad categories: organic and psychological disorders.

- Culture as Epiphenomenon: Culture is understood as set of beliefs which are superimposed on the reality of biology. Such beliefs are often disparagingly regarded as merely misinformed or superstitions. This concludes in a disregard of conceptions of illness, illness experience and healing practices of other cultural groups. At its worst, it is regarded as an obstacle in diagnosis, treatment compliance and outcome.

In the Vietnamese culture, health is very much connected to religion and tends to emphasise the holistic or integrated notion of human existence (Nguyen, 1990). The Vietnamese have for generations practiced Buddhism, Confucianism and Taoism. Buddhism, however, has its greatest influence in the area of health. According to the Buddhist scriptures, life is a vast sea of suffering in which one wallows hopelessly. In effect, the vicious circle of existence is renewal in the course of endless reincarnation. The cause of suffering (and illness) is desire: desire for life, happiness, riches or power. If desire were suppressed, the cause of pain would be destroyed. The essence of Buddhist teachings is contained in the concept of Karma, the law of causality. Karma explains that the present existence is conditioned by earlier existences and will condition those which follow. Therefore, the virtuous person should strive constantly to improve by doing good deeds and by renouncing sexual pleasures in order to become conscious of Buddha who is present in every living being. Consequently, desire must first be overcome and a pure heart is necessary to break the chain of suffering in this earthly existence before the state of bliss called Nirvana can be attained. Religion, medicine and ethics are integrated together and a sharp dichotomy between mind and body is not evident (Liem in Nguyen, 1994:50).

Most Vietnamese perceive a disturbance of thought, emotion or mental activity that clearly interferes with the ability to have relationships, work and enjoy life not so much as manifestations of illness, but rather, as a predicament or punishment which they have to repay for the misdeeds. The misdeeds could either be caused by their ancestors in the past, in their own private lives or they accept as a fate because they were born at an unlucky astrological time or their relatives unfortunately died at a bad time. Other explanations point to the belief that they could be possessed by evil spirits, casting of a magical spell by a sorcerer or due to their relatives' graves being misplaced or placed in the wrong direction (Lien in Minas and Hayes, 1994:56).

Within this concept of health, Eisenbruch (1990:73) argues that Karma is interesting because if one considers someone who believes that illness is caused by predestiny, that is from bad merit accumulated in the past life, it raises some ethical as well as some medical questions. The question here is then *how does one try to change the patient's behaviour when the patient believes that there is nothing to be done in this world and that it is better to earn merit to enable a better rebirth in the next?*

The stigma attached to mental illness is very strong. Bakshi, Rooney and O'Neil (1999:8) state that in many CALD communities, culturally embedded attitudes and beliefs towards mental illness involve negative connotations. Reactions towards people suffering from mental illness include avoidance, ridicule, rejection, fear and considering them as bad, dangerous, weak or incurable. Subsequently, these attitudes toward people with mental illness further reinforce the negative label within the community. Lien (Minas and Hayes, 1994:55), a Vietnamese psychiatrist in Australia, explains that regardless of the social class of his Vietnamese clients, most still hold the concept of mental illness of more than a century ago. Mental illness is equivalent to being mad and a disgrace not only for the clients but also for their families. It is regarded to be a very shameful condition affecting the dignity of their ancestors, their extended families as well as their nuclear families. It may also affect the family's economic status and the client and members of his/her family may have

difficulty in getting married. The reluctance to seek treatment from a psychiatrist is understandable. In order to help minimise the stigma, Lien operates under the term 'Bac Si Tinh Than', which means 'a spiritual doctor' who provides 'emotional support' and 'cares for the mind'.

Vietnamese conceptions of illness and health are also influenced by naturalistic or folk medicine, supernatural or animistic beliefs, and metaphysical explanations or Chinese hot and cold theory (N.T. Tran, 1980). The combination of all these factors may have led to a diversity of conceptions of mental disorders thereby reducing the likelihood that a unitary psychiatric nosology would emerge from that culture.

Research for Vietnamese explanations of health and illness presents a difficult task because many key texts were destroyed or dispersed during and subsequent to the prolonged wars in Vietnam, especially during the "literacy crusade" that was initiated after 1975. (Phan, Tuong, Silove and Derrick, 1999:82). It is believed that the "Y Hoc Yeu Gai Tap Chu" of Chu Van An (1466) was the first Vietnamese medical text documenting an indigenous physician's observation of the aetiology, clinical manifestations and preferred treatments for epidemic and infectious diseases (T.Q. Nguyen and N.H. Nguyen, 1990). There has been very few medical texts and they were written either in Chinese or in the original form of the Vietnamese language, Chu Non. One of the most famous text the 'Hai Thuong Lan Ong' has been translated into contemporary Vietnamese language and this doctrine consists of 65 volumes and was written during the late 15th to the early 16th century by a respected Mandarin of the Le Empire, Le Huy Trac (V.N. Nguyen, 1995). His doctrine provides a comprehensive taxonomy of mental illness but the psychiatric aspects of diseases and the psychological elements of interventions were not defined or discussed (Phan, Tuong, Silove et al, 1999:83).

Definitions of terms like the word "psyche" reveal that the absence of an independent description of psychiatric illness in Vietnamese traditional medical text may be attributable to the monastic conceptions of which

Vietnamese medicine was based. The concept of psyche and physical health is underscored by the term "tan than" (psychiatry) which was defined by the Tdien Dong Y Hoc Co Truyen (Eastern Traditional Medical Dictionary). The term "psyche" includes aspects of energy and central nervous systems functionings and it relates to the general functioning of the brain and the heart. Psyche is the term describing the overall function system of life (Phan, Tuong, Silove et al, 1999:84). In relation to abnormal mental functioning, the tract states that the psyche is located within the heart. When the heart and/or psyche is injured the psyche manifests itself as a mental abnormality.

A condition called "tam trung dam dam dai dong" (an extreme excitement of psyche and an empty feeling) was described as an example of an abnormal psychological functioning. This condition was believed to be related to physical factors, especially excessive 'am' (negative charge) which leads to an imbalance of energy and body heat. This imbalance in turn disturbs the psyche, the symptom of which is irritability, mental lethargy and a weakened pulse. Treatment depends on minimising the 'am' by strengthening t' > duong (positive charge). The biological nature of 'am' and its psychological affects seem to be associated with the phenomenon of Yang which is the central element of Chinese medicine. N.T. Tran (1980) stressed that a single term such as "suy yeu than kinh" (witness of the nervous system) is used to denote a diversity of conditions. These could range from bizarre behaviours/actions to excessive worry or extreme sadness. It appears therefore, that both the holistic concept of human experience which is central to Buddhism and Confucianism, as well as the eclecticism of folk beliefs, may have combined to produce variability in the indigenous usage of terms that describe the psyche phenomena (Phan, Tuong, Silove et al, 1999:84).

3.4.1 Influence of Chinese Culture on Vietnamese Concept of Health and Illness

According to K.B. Phan (1960), the Vietnamese became familiar with Chinese medicine as early as the Ho Han Suong empire of the 15th century when a Chinese hospital was established to serve

the king and his royal family. Others, for example, D. Tran, (1990), have documented that traditional Chinese medicine has been practiced in Vietnam for thousands of years. This raises questions about the extent to which the two medical cultures (Chinese and Vietnamese) have had an influence on one another (Phan, Tuong, Silove, 1999:85).

The main framework of Chinese medicine was derived from the biophysiology concept of the Yin and the Yang, as well as the cosmological concept of the five elements. Chinese medicine, with all its physiological, anthology, diagnosis and treatment, can all be reduced to the basic and fundamental theory of Yin and Yang. Every physiological process and every symptom or sign can be analysed in the light of the Yin-Yang theory. Every treatment modality is aimed at one of the four strategies: to tonify Yang, to tonify Yin, to eliminate excess Yang and lastly to eliminate excess Yin (Marciocia, 1989:7). In relation to mental phenomena, restlessness, insomnia, fidgeting or tremors indicate excess of Yang. Withdrawn behaviour, immobility and sleepiness indicate excess of Yin. Likewise, excitement or hyperactivity, for example, rapid heart rate is caused by an excess of Yang while inhibition or hypoactivity reflects the state of excess Yin (Phan, Tuong, Silove and Derrick, 1999:86).

The five-element concept maintains that a person's wellbeing is much affected by particular components of his/her environment. The environment is made up of five elements: earth, wood, fire, metal and water. The latter four elements each represent one phase of four season cycle: spring, summer, autumn and winter. All these four seasons interact interdependently with the earth and consequently govern human biophysiological functions and psychological wellbeing. The mental component is not considered as having an independent identity but is integral to a human's health and wellbeing (Phan, Tuong, Silove and Derrick, 1996:86). According to Marciocia (1989:129), Chinese medicine views the

body-mind not as a pyramid but a cycle of interaction between internal organs and the emotional aspects. Any disturbance of the interrelationship between the five elements would systematically disturb the bodily functions as well as the persons emotional and mental wellbeing.

3.5 CONCLUSION

The importance of discussing the concept of culture lies in the fact that it forms the basis of the main thrust of this research. Although there have been many explanations of this term, there is general agreement that it is not inborn, but rather, a collection of socially constructed characteristics that members of a specific group inherit. These traits are in a constant process of change and adaptation and are not static. An insight and understanding of the concepts of mental health/illness from both Western and Eastern perspectives is extremely important if we are committed to providing culturally effective and meaningful mental health services. Comparisons of these definitions reveal the differences in which members of different cultures conceptualise mental health/illness and that there is no one single definition that can claim to hold true for all cultures. Understanding these concepts from a Vietnamese viewpoint form one of the key prerequisites towards bridging the gap between the Western-trained practitioner and the client.

Chapter 4

LITERATURE REVIEW

4.1 INTRODUCTION

This chapter aims to have a better understanding and insight into the historical, political, social and cultural background of the Vietnamese. It is divided into the following headings:

- Historical/political events which led to the refugee exodus;
- Social issues associated with the refugee settlement, namely language difficulties, unemployment, accommodation and family life and settlement;
- The Vietnamese cultural self, which includes the four main aspects of interaction guiding social/cultural behaviour; and
- Health seeking behaviour among the Vietnamese.

In order to provide culturally appropriate care and treatment to those needing it, it is important to understand their historical, political, social and cultural backgrounds. This is even more so when they originate from a country that is culturally and traditionally very different from the culture that they have moved into, and in particular, when these settlers had undergone tremendous psychological, emotional and physical hardships (Thu, Cahill and Bertelli; 1989:30). According to Minas, Lambert and Kostov and Boranga (1996:147), the education of mental health professionals should include, sufficient knowledge about the circumstances of immigration of various groups (eg. refugees), the challenges of immigration and settlement and the implications of these for general and mental health. Under the National Health Standards for Mental Health Services, Standard 7 deals with the need for cultural awareness. Criteria 7.1 states that staff of the mental health services should have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances (National Health Standards, 1996:16).

4.2 HISTORICAL/POLITICAL EVENTS WHICH LED TO THE REFUGEE EXODUS

In 1975, a major event in Vietnam caused thousands to leave in a mass exodus across both land and sea. The country was rocked by sudden changes in the government. The war which broke out between North and South Vietnam and which led to the eventual take over of the entire country by the Communist regime of North Vietnam, caused enormous personal costs, both material and psychological to the populace. The change in the political leadership and ideology led many supportive of previous governments to flee, fearful of the consequences of their political allegiances. Initially, the people who departed were those who were working under the capitalist regime of former South Vietnam. However, the general populace soon followed suit, ranging from the educated urban elite to farmers and ethnic minorities. (Thomas, 1999:8).

Despite the expected dangers associated with the perilous journey by sea and land, it did not deter the people from escaping due to fear of losing their lives (Krupinski and Burrows, 1986:1). According to Ly and Lewins (1985:1), some 200,000 Vietnamese escaped from South Vietnam during the days immediately before and after the fall of Saigon (former capital city of South Vietnam) to the Communists on the 30 April 1975.

Throughout the history of Vietnam, from 111 BC when the Chinese annexed Vietnam under the Han Dynasty to the Communist take over in 1975, the country struggled with fighting off foreign powers in an attempt to gain independence. The Chinese ruled Vietnam for more than a 1000 years and according to Thomas (1999: 4) and Thu (1994), it had a major influence in the religious, social and political arenas. Vietnam had such strong Chinese values and ideas in its cultural and political life that it has become impossible to make the distinction between what belonged to Vietnamese culture and what belonged to Chinese culture.

The domination of French rule was from 1884 to 1945, roughly a period of 80 years (Bennoun, Bennoun and Kelly, 198:36). During this time, vast transport and communications networks were created and there were also advances in industrial development, education and medical facilities. However, the Vietnamese experienced these achievements against a backdrop of a ruthless and exploitative regime. The use of forced Vietnamese labour for these developments mainly benefited the colonial power. The rationale for most of these developments was to utilise the raw materials, like rubber and minerals (Bennoun et al, 1984:45). The French during this period also had control of the neighbouring countries of Laos and Cambodia, which together with Vietnam is called Indo China. The French concentrated on making over-populated Vietnam productive and economically viable but left Cambodia and Laos neglected (Krupinski and Burrows: 1986:2). It was however, during this period of French rule that the nationalist movement in Vietnam grew which involved intellectuals, writers and other patriots.

In 1927, the Viet Nam Quoc Dan Dang (Vietnamese Nationalist Party) was established in Hanoi. Against the strong forces of the French, several insurrections organised by this Group were crushed. In 1930, the Indo-China Communist Party was formed under the leadership of Nguyen Ai Quoc, better known in history as Ho Chi Minh. In the late 1930s, much of the nationalist movement came under communist control and in 1941, the League for the Independence of Vietnam (Viet Nam Doc Lap Dong Minh Hoi) was established and became commonly known as Viet Minh (Bennoun, Bennoun and Kelly, 1984:45). Again, the overall purpose was to fight against foreign rule in order to gain independence.

Japanese intervention during the World War II, however, disrupted French rule. In 1945, six months before the end of World War II, the Japanese deposed the French administration and proclaimed the independence of Vietnam. After the Japanese surrender in August 1945, the Viet Minh party led by Ho Chi Minh assumed power, and proclaimed the Democratic Republic of Vietnam in September 1945 (Bennoun et al, 1984:46). The French, once again, regained the South, and with the help

of the United States and England, the new Vietnamese regime was forcibly removed. The United States involvement with the French was an effort to stem the spread of Communism. In December, the Viet Minh attacked French troops after it refused to resume negotiations with them. This attack marked the official beginning of the Indochina War (Krupinski and Burrows, 1986:2). The French were crushingly defeated by the Viet Minh in the battle of Diem Bien Phu. This was followed by the 1954 Geneva Conference where the major powers and rival Indochinese factions agreed to the temporary division of Vietnam (Krupinski And Burrows, 1986:2).

The long Indochinese wars have a broadly accepted timeframe. The first was the struggle against French colonial rule (1945-54) and the second was the civil war between South and North Vietnam due to different political ideologies (Lewins and Ly, 1985:2). The 1954 Geneva Agreement effectively created North and South Vietnam. The great powers at that time – France, Great Britain, the United States, the Soviet Union and China – were involved in this Agreement in which a political settlement embodying 'respect for the principles of independence, unity and territorial integrity' was to be upheld. This was to be expressed in the free general elections to be held in July 1956. However, not all the great powers signed the Agreement and the elections were never held. The temporary demarcation line at the 17th parallel became a permanent political boundary dividing North and South Vietnam (Lewins and Ly, 1985: 3).

The North was supported by China, Soviet Union and other communist countries whereas the South was supported by the United States. In 1955, Ngo Dinh Diem, a Catholic, proclaimed himself president of the republic of South Vietnam and stabilised his anti-communist regime with massive financial aid from the United States. His reign, however, was fraught with a policy of discrimination favouring Roman Catholics in the army and the bureaucracy (Krupinski and Burrows, 1986:2). Massive demonstrations of Vietnamese Buddhists occurred and several Buddhist monks committed suicide by setting fire to themselves as a protest

(Bennoun, Bennoun and Kelly 1984:47). The intellectual elite was demoralised by the denial of civil liberties and in 1963, Diem was assassinated. The political internal conflict deepened even more with his assassination and there were several changes in the government before the military was able to gain control in 1967 (Krupinski and Burrows, 1986:2). In a series of coups in the period from 1963 to 1975, nine changes of government took place in South Vietnam (Bennoun et al, 1984:47).

It was this period which witnessed a large scale of displacement of the population. Saigon and other cities became centres for refugees who fled the North for fear of the Viet Minh. Similarly, in the North, centres not under Viet Minh control became refuges for Catholics of all classes as well as for the village middle class elements. The most notable movement, however, was the movement of the Northerners to the South. The hundreds of thousands who left were genuine refugees who believed that a communist regime would expose them to danger. They abandoned many possessions and most were evacuated by the French and American forces (Lewins and Ly, 1985:2).

Meanwhile, the Viet Cong guerillas (Vietnamese communists) in the North went from strength to strength until American military experts concluded that the survival of the South was seriously threatened. In March 1965, the United States president, Lyndon Johnson, ordered the bombing of North Vietnam with the aim of restricting further infiltration of arms and men into the South. Large numbers of Americans and their allies, including Australia, were committed to Vietnam to help resist the invasion of the South by the North. As the prolonged war became more and more unpopular with the West, the United States began gradually to withdraw from Vietnam from 1970 onwards (Krupinski and Burrows, 1984:2). In 1973, after intense negotiations, a cease fire called the Paris Agreement was signed on the agreement that all non- Vietnamese forces be withdrawn. However, the Agreement was never fully implemented. The decreasing military and financial support from the United States for the South combined with a series of military victories from the North

eventually saw the collapse of the South Vietnam regime. On the 30 April 1975, North Vietnam captured Saigon and claimed victory for the North (Bennoun, Bennoun and Kelly, 1984:48).

The prolonged war and its aftermath caused great social divisions based on ethnicity, regional differences, class, religion and political attitudes towards the communist regime in Vietnam. The part of the population with the most to lose were the southern elite, the Chinese and the Catholics who formed the main body of refugees to escape from Vietnam through four successive waves between 1975 to 1982 (Viviani, 1984 in Krupinski and Burrows, 1984:5). The first wave was mainly the southern elite who had well placed jobs within the government and military administration. The second wave (from June 1975 to late 1977) comprised mainly urban middle-class Vietnamese who were not happy with the social and economic persecution, loss of personal freedom, internment in re-education camps and fear of being sent to new economic zones. The third wave was predominantly Chinese who fled as a result of anti Chinese feelings resulting from border tensions between China and Vietnam. This led to the government's closure of private businesses and the exploitation of traditional Vietnamese resentment towards the ethnic Chinese who were also Vietnamese citizens. The fourth wave of the refugee exodus consisted of an orderly migration programme. A conference held in Geneva in 1979 resulted in a decline in departures. This conference was held to discuss 'Refugees and Displaced Persons in South East Asia'. As an outcome of the conference, Vietnam declared a moratorium on the outflow of boat people (Viviani, 1984 in Krupinski and Burrows, 1984:6).

Between 1975 and 1982, it is estimated that more than a million refugees left Vietnam but many perished in their escape (Krupinski and Burrows, 1986:5). The bulk of them left by boat, which were not fit to ensure a safe journey. The boats were often overcrowded, the journey was extremely dangerous and lives were lost through drowning, starvation or murder by pirates (Thomas, 1999:9). Of the million who have escaped, more than 40,000 remained in refugee camps in Hong Kong and South East Asia

and were slowly repatriated back to Vietnam as pressure mounted on Vietnam to accept them back (Thomas, 1999:10). According to Krupinski and Burrows in Hosking (1991:12), it is estimated that pirates robbed 30% of the boat people and over 10% were raped or abducted. Nearly 100,000 died in stormy seas or by starvation. Hosking (1991:12) related a story as told by one of the survivors:

'They boarded their boat. They stripped and robbed the refugees and threatened to rape one of the women. One Vietnamese took out a gun and shot one of the pirates. The pirate boat went away but returned with four other boats about five hours later. They circled the refugee boat, taunting and terrifying the occupants. The man with the gun fired at them until he used all his bullets. Then they came. They boarded and found the man. He was beaten until he fell on the deck. A large knife was put in his mouth and his head was hammered to the deck. The pirates then ran amok. Women were viciously raped. The Vietnamese stood by helplessly as six pirates repeatedly raped an innocent thirteen-year-old girl. Children were thrown overboard. The boat was left a blood-splattered mess. The only survivors were three people who managed to hold onto the underside of the boat after they were thrown into the sea.'

4.3 SOCIAL ISSUES ASSOCIATED WITH THE REFUGEE SETTLEMENT

Between April 1975 to 1983, Australia accepted 62,574 refugees from Vietnam (Krupinski and Burrows, 1986:8). The psychological impact of the refugee experience has been well documented in many studies and has been discussed at length in Chapter One. In addition to the psychological trauma that many underwent, they were also confronted by a number of other challenges. For the Vietnamese refugees, the post-arrival experience was perhaps the most significant stage of their settlement in Australia. During this period, the greatest difficulties of adjustments became realised for many and the foundations of permanent attitudes were laid (Ly and Lewins, 1985:29).

The composition of these refugees were not homogenous - they ranged from Chinese merchants to rural fisherman, from school teachers to high ranking officials. As a result, it complicated the government's effort to

provide for their needs, particularly in the area of employment (Ly and Lewins, 1985:29).

Many arrived here with preconceptions about the availability of work, retraining schemes, education and government support. Knowledge about these were gained through documents on life in Australia circulated in refugees camps in Hong Kong, Malaysia and Indonesia. Most in fact, had very little idea about life in Australia and were unprepared for the inevitable change in lifestyle. Feelings of disorientation were not uncommon and many felt that they had lost control of their destiny (Ly and Lewins, 1985:29). According to Freize in Krupinski and Burrows (1986:9), language difficulties and the lack of a job or suitable employment were the most common problems reported by refugees in adjusting to life in Australia. Other associated problems like accommodation and family life also took an emotional stress on these refugees.

4.3.1 Language Difficulties

Communication was a major problem for these refugees. A study of the first wave of Vietnamese refugees into Australia showed that out of a total of 537 individuals in the study, 88.7 per cent (383) spoke little or no English, while only 2 per cent (9) had a useful working knowledge. The Keys Young study also showed that another group of Vietnamese refugee arrivals had similar trends, with 87 per cent having little or no English on arrival while 2.6 per cent were fluent in English (Ly and Lewins 1985:30).

The inability to understand English was one of the main obstacles preventing Vietnamese refugees from having a smoother settlement transition. Issues arose such as difficulty in understanding hostel staff, Social Security or the Commonwealth Employment Service. Authorities did not have much luck in communicating effectively with the refugees due to the lack of on the spot information in the Vietnamese language and the

insufficient number of interpreters available. Communication was a major issue for both sides (Ly and Lewins, 1985:30).

Apart from the inability to obtain knowledge about welfare services, the lack of English also caused acute difficulty in health problems. A case was related when a refugee gave birth to a child in hospital. The parents became suspicious of the infant's birth because it was not explained to them why the child was taken away to be examined and why they were not immediately told of the sex of the child. The separation from their child during the whole process caused considerable distress compounded by the communication between hospital staff and them (Ly and Lewins, 1985:31).

The problem of using interpreters for the first wave of Vietnamese refugees was quite serious. In one case study reported, a hospital used to get Vietnamese students who were studying in Australia at that time to interpret for them. It was found that many of these student interpreters were insensitive and arrogant. In another case study, the use of a Vietnamese refugee who could speak English also faced difficulties. The veracity of this refugee interpreter was also thought to be insensitive to the problems faced by these refugees. This interpreter was accused of misinterpreting by them by putting forward his own value judgement instead of theirs. Some of these refugees felt unsure that what they were being told by the interpreter was in fact the true situation. Others felt that the interpreter knew too much about their private matters. Other refugees also resented the fact that their private matters were discussed with the refugee interpreter without permission. Finally and most importantly, many felt that information interpreted was misinformation and could be used to cheat them of entitlements. As a result, many felt that aid from such organisations as St Vincent de Paul was either withheld or unevenly distributed because of this interpreter. They could not trust that he was prepared to help them without considering his

own self interest. What was really surprising, however, was that neither the hostel or welfare staff was aware of the antagonism between the interpreter and the refugees (Ly and Lewins, 1985:32).

Although English classes were available, the level of attendance differed markedly among people of different age groups. It was found that the younger the refugee, the better was the command of English at the end of a 2 year study. Only 11 per cent of adults achieved a fair level of understanding, whereas 16 per cent had not acquired any understanding at all. This resulted in the adults having to depend on the young ones to interpret for them. Their once authoritative and hierarchal position which was held high in a traditional Vietnamese culture had been completely taken away from them as they had to depend on the younger ones for their communication. Instead of being the heads of their families, they were now subject to having to depend on others for their social survival in a culturally alien country (Krupinski and Burrows, 1986:235).

Improvement in the English language among the younger refugees made them realise the drawbacks and difficulties that confronted them. As a result, this made many adolescents realise that opportunities would only arise if they had a high level of English language. It has propelled many of them to improve their language skills so as to enable them to pursue further tertiary studies.

4.3.2 Unemployment

The level of unemployment amongst the Vietnamese was one of the highest for any immigrant groups in Australia. The low levels of English proficiency together with the extremely high levels of unemployment indicate in the long term that if this pattern is not checked and something done about it, it is probable that an underclass of unskilled and unemployed Vietnamese will develop

(Thomas, 1999:25). At the 1996 Census, unemployment stood at 19.2 per cent for Vietnamese residing in Western Australia as compared to 8.1 per cent for all other Australians. Over 60 per cent of this group have an income of less than \$300 per week, in comparison with 49.3 per cent of the total population. Those working were concentrated in lower paid jobs, with 28 per cent in the lowest skilled category and 22.8 per cent employed in intermediate skilled occupations (Visser and Beer, 1999:130). The hardest hit in the labour market were the Vietnamese women. Generally, the disadvantages experienced by CALD women were explained in terms of their relative lack of relevant human attributes (Viviani, Coughlan and Rowland (1993:5). Wooden (1990) in Viviani, Coughlan and Rowland (1993:5) suggests, however, in the case of the Vietnamese women, this high level of unemployment may be due to the adjustment problems during settlement. The lack of preparation before emigration, experiences of torture and trauma and past disruptions to education and working life all have a negative impact in the labour market.

Jupp (Minas and Hayes, 1994:27) warns that there is a danger that some refugees may be forming the core of an 'underclass', a development that all official settlement aims to prevent. With lower levels of education, skill and English competence, many have difficulty in seeking employment which can pay them wages equal to or above the national average.

Other factors also contribute to the high unemployment rate. Short period of residence in Australia and the difficulties adapting into a very different culture in the first few years also accounted for the high levels of unemployment.

Another factor also impacting on unemployment levels is age. Unemployment is high for youth and those over 45 years. Although this trend also applies to other Australians, this 'twin peaks' phenomenon is specially obvious among the Vietnamese.

The final factor is the lack of qualifications or the non-recognition of overseas qualifications. About 80 per cent of those who arrived here as refugees from Indochina have no post-school qualifications. Those who do have qualifications have difficulties in having them recognised (Viviani, Coughlan and Rowland, 1993:89).

Jones and McAlister (1991) in Viviani, Coughlan and Rowland (1993:5) in their study of Vietnamese unemployment, point the problem to racial and systematic biases operating against (Lebanese) and Vietnamese immigrants not observed among the immigrant work force as a whole. Marshall and Williams (1991) in Viviani, Coughlan and Rowland (1993:5) draw similar conclusions and maintain that there have been ongoing and systematic evidence of discrimination at the general workforce involving, in particular, immigrants from CALD backgrounds. Viviani, Coughlan and Rowland (1993:91) assert that many Vietnamese workers have reported discriminatory behaviour in losing jobs, as expressed in the usual Vietnamese term 'the black hairs go first' in a Brisbane survey on Vietnamese unemployment. It reported that it is practised particularly against those whose level of English is low, although those who are educated and have a better command of the language are also affected in more subtle ways. Other studies conclude that there has been substantial occupational downgrading for Vietnamese on arrival in Australia. This is a point made in a few studies on the issue by Strombock (1992), Viviani (1984), McAlister (1992) and Iredale and D'Arcy (1992) in Viviani, Coughlan and Rowland (1993:4).

All the macro studies done on Indochinese unemployment by Jones (1988), Collin (1988), Wooden (1990) and Jones and McAlister (1991) in Viviani, Coughlan and Rowland (1993:5) agree that lack of English language proficiency, periods of residence, age, gender and education are the major factors that make the difference between CALD immigrants and other Australians. The

disadvantageous impact of these factors in the labour market, however, diminishes over time. After a period of five years or more, the level of labour market participation more closely resembles that of Australian-born.

4.3.3 Accommodation

Refugees were normally accommodated in hostels based in some capital cities in Australia on arrival. A report by the government entitled 'Please listen - What I'm not saying' (1982) states an average length of stay in a hostel for the Vietnamese refugees to be 5-7 months. The first wave of Vietnamese refugees stayed on an average of 8.5 months mainly because of the lack of back-up support services at that time. Those under the greatest financial strain tended to stay longer than others and they included families without male bread winners (Ly and Lewins, 1985:33).

Although it was a relief for many of these refugees to be accepted into Australia, hostel life was not without its problems. Conditions in hostels were cramped. Not only that, poor and inappropriate type of food resulted in many cooking for themselves. This added an extra burden on the financial situation as they not only had to pay for the hostel food that they found culturally inappropriate, but they had to spend money on buying foods that were more palatable to their diet. Others complained of discrimination in the distribution of food and poor organisation on the part of hostel staff. This caused unnecessary stress which could have been avoided with better organisation (Ly and Lewins, 1985:33).

Exiting from hostels have also created anxieties for refugees. Issues arose such as finding cheap accommodation, dwellings big enough to accommodate extended families, close to work and staying within close proximity to services like Social Security. Several tendencies appeared during this transition. Many sought housing as close to the work place as possible to reduce travelling

costs. For instance, in Sydney, many lived in the Western suburbs where most were employed as factory workers there. In Brisbane, many ended up in suburbs around the hostel on the outskirts of the city where accommodation was considerably cheaper. The other noticeable feature is that they tended to settle in a few concentrated areas as a means of providing an emotional and social support structure in the initial stages of life in the wider community (Ly and Lewins, 1985:34).

The Vietnamese have a concentrated pattern of settlement and this has been a feature of their distribution all over Australia. They are a highly urbanised community. For instance, in Western Australia, they are overwhelmingly concentrated in Stirling Central SLA, South East Wanneroo and Bayswater in Perth. At least 96 per cent of them live in the Perth metropolitan areas. Outside of these locations, there are relatively few Vietnamese (Visser and Beer, 1999:130). The direct connection between unemployment and residential concentration is clearly reflected in a study of the Vietnamese residing in Brisbane. Unemployed Vietnamese tend to live in areas of residential concentration in Brisbane as housing is cheaper and these are areas of public housing and near access to community services. Patterns of residential concentration, however, are more complex than direct connection with unemployment. For instance, although there is high residential concentration of Vietnamese in two areas of Brisbane, it camouflages the dynamic nature of settlement patterns. Social differentiation and social mobility do have a significant impact on movement within suburbs of concentration (Viviani, Coughlan and Rowland, 1993:92).

Period of residence is also central to residential dispersion. It is a surrogate for employment, level of English proficiency, accumulation of capital and income and all these factors improve for most Vietnamese as their period of residence become longer.

In Brisbane, for instance, the patterns of dispersion are determined by class, status, periods of residence and ethnicity (Viviani, Coughlan and Rowland, 1993:92).

In conclusion, on the distribution of settlement for the Vietnamese community, their attributes, level of employment, differentiation in the community, the markets they enter and the impact of public policy, both local and state all have an impact in shaping the decisions they make (Viviani, Coughlan and Rowland, 1993:92).

4.3.4 Family Life and Settlement

Traditionally, the Vietnamese family have been structured around an extended family system. There has always been a strong emotional and instrumental reliance on the family. This basic extended family, which is the cornerstone of Vietnamese culture, has often been fragmented due to the refugee experience. However, among the first wave of Vietnamese refugees who arrived in Australia, only a little over half consisted of even the most basic nuclear family. Many consisted of families with spouses, parents and/or children missing. Also the risks and the cost of escaping from their homelands deterred large family groups and this resulted in the breakup of the extended family unit for many refugees. For example, one quarter (24.6%) of the children and the vast majority of adolescents (76.6%) and young adults (88.5%) left Vietnam without a parent. In addition, 17 per cent of the adolescents and one quarter (25.1%) of young adults escaped alone. The fact that substantial numbers of incomplete families escaped from Vietnam raises the question of whether these families are more at risk than other groups (Burrows and Krupinski, 1986:86). Many family members had also been lost in the panic of leaving Vietnam and have not been contactable since. As a result of all these factors, many had to learn to manage without the close extended and nuclear family support to which they were accustomed. This kind of support had often provided a comfort zone physically and emotionally. The dislocation and

displacement of family members has created a serious vacuum in the traditional Vietnamese family. For many, it was probably the most tragic and traumatic experience of their lives (Ly and Lewins, 1985:35-36).

For those who managed to contact their family members back home, or at refugee camps, a common feature observed has been that many started to send money and goods back home to either help them escape and/or to support them financially. As a consequence, their own resources were depleted and it created a longer period for them to be properly settled in their new homeland. Many considered helping members of their families left behind more important than helping themselves first and therefore have expended all their energies in getting family members out of Vietnam or camps (Ly and Lewins, 1985:36). As a result, many had the notion that they would have to work hard to earn sufficient money to send home. Many of their relatives back home had depended so much on them sending money back that it had often created stress as the requests for money were often continual (Krupinski and Burrows, 1986:115).

The vast quantity of money and merchandise that travels to Vietnam every month attests to the strong family ties these immigrants have with their relatives back home. Some individuals who have not seen their relatives in Vietnam for a long time strengthen their bond almost entirely through massive flows of letters, money and goods. Many feel guilty if they spend money on themselves as they know that those left in Vietnam may still be suffering:

'I cannot buy a lot of clothes. I feel that I must only buy the basic type of everything; a basic car, house, furniture. I try to get everything cheaply. My friends always discuss where to get a good buy. If I spend too much I feel sick in my heart for my family back in Vietnam. Even the most basic lifestyle here is extreme luxury to Vietnamese' (Thomas, 1999:189).

As a consequence of coming to Australia in 'make do' family units, problems started to emerge in hostels and in their own dwellings. This is because relatives were either not relatives at all or were more distant than the official records showed. Many claim family relationship with each other while they were interviewed by immigration authorities mainly to ensure a better chance of acceptance. Problems often arose when some individuals expressed their desires to leave the family and were exacerbated by the close quarters in which they live. For instance, either a neighbour or a servant was considered a family member when accompanied. This created problems when disputes arose because the person wanted to live elsewhere (Ly and Lewins, 1985:36). In two cases recorded, individuals have made suicide attempts, apparently a direct result of being tied to families that they had problems with. The result of the falling out of many of these informal groupings was that there were more single individuals having to cope on their own than one would have expected from the original Department of Immigration family list (Ly and Lewins, 1985:38).

Some marriages were under great stress. Finding concrete causal links between failed marriages and the refugee status of the Vietnamese was problematic. The stress of migration on an already precarious mental situation may have exacerbated the situation, particularly as the strong family support networks in a traditional Vietnamese culture have been torn apart. One young couple who sought divorce less than a year after their arrival, separated due to different approaches and ideologies to life in Australia (Ly and Lewins, 1985:38).

Other complications also crept into family life. Older children had to forgo their ambition of furthering their studies because they had to work in factories to supplement the family income. Wives who were also compelled to work for the same reason often destabilised the emotional tenor of family life. Parents felt guilty

that the children were working instead of studying, as they would have wished if circumstances were different. On the other hand, many children resented the fact that they could not fulfil their ambition to pursue higher studies. The restriction also included the fact that their proficiency in the English language was not high enough for them to pursue higher studies. This had the general effect of dampening families' ambition of establishing themselves in Australia (Ly and Lewins, 1985:39).

A study done by Ly and Lewins (1986:39) on Vietnamese refugees a few years after they have settled in Australia indicates that one of the most important changes was the change among Vietnamese children. Many Vietnamese parents see their children slipping from the traditional Vietnamese mode of family life. Many of these children acquired Australian cultural standards which not only offended parents' sensibilities, but created some serious concern that their children may not care for them in their old age. While many Vietnamese take out naturalisation and even give their children Australian names, this adaptability appears not to have changed their traditional view of family life. Thomas (1999:80) reports that in Vietnam, older people are respected for their greater knowledge and experience. One is believed to become wiser as one grows older and this belief places older people in a very respected position of being the bond between generations, as well as the spiritual world of ancestors and the material world of the present. This position between the sacred and the profane accords them the responsibility of merging and consolidating the different family members into a united and harmonious society. In Australia, this position has been eroded due to the younger generation taking on western values and attitudes. The following comments from a Vietnamese lady in her 70s illustrates the decaying Vietnamese values among the younger generation.

'I felt as though the whole family were strangers to me. My grandchildren had to be forced to speak Vietnamese to

me, and so often didn't even want to speak to me at all. My own children had such independence that I was shocked I found that the hardest thing to cope with was that I wasn't needed any more. No one asked me for advise, and when I offered suggestions my children would often laugh ' (Thomas, 1999:82).

4.4 THE VIETNAMESE CULTURAL SELF

Roland (1984), Kohut (1977) and Sherif (1982) in Meemeduma (1987) use the concept of self as an organising characteristic of the psychic to express the intrinsic authenticity of the individual. In Sherif's assertion (1982:381), self "encompass a constellation of attitudinal schema, formed during development through interactions with physical and social realities. Self schemas thus centres around experiences of 'me', 'I' and 'mine'". They relate to the body, its parts and capabilities, with social objects, places, activities and time schedules and with groups and the most prominent factor affecting the nature of the cognitive appraisal process is the 'framework of understanding' utilised by the individual to describe and evaluate interactional processes.

The framework of understanding in this self is culturally bound. According to Meemeduma (1987:1), it is this world of cultural meaning which serves to shape the concept of self as well as the enactment of meaning of social relationships. Cultural meanings determine not only the way we think of ourselves but also what we think of ourselves. It also shapes the self as social actor by shaping the context within which each of us organises social meaning. What is thought, said and acted out about self and others will be shaped by the concept of cultural self and manifested in the process of socialisation. Kakar (1981) and DeVos (1980) in Meemeduma (1987:3) assert that cultural self is shaped during the earliest socialisation process and is one of the most enduring cultural dimensions and the one most resistant to change. Even when the individual is dislocated from his/her own country of origin, the cultural concept of self remains to shape the nature of social interactions undertaken in the new environment.

Blair in Radley (1993:28) explains that a number of authors have identified the differing concepts of 'self' in their identification of cultural and historical differences in the experience of distress. He quotes Marsella (1984) as contending that mental disorders cannot be understood apart from the concept of self. This is because it is the nature of self which serve in the construction of reality for a given cultural group and which dictates the definition of what the symptoms will be. For instance, within Western cultures, consciousness has been conceptualised as more 'reflective' and 'internalised' than non-Western cultures.

At this forefront, it must be understood that Vietnam was under Chinese domination for at least one thousand years (C.K, 1984:33). The Chinese rule began in 111 B.C until 939 A.D. when Ngo Quyen, an army official, defeated the Chinese armies and established the first national dynasty of an independent Vietnamese kingdom. Even though Vietnam was once ruled by the French and the Japanese, the influence of China was most far reaching (Bennoun, Bennoun and Kelly, 1984:40). It is therefore, important to understand that the Vietnamese cultural self is very much influenced by the prolonged domination of Chinese rule. For instance, the official religion of Vietnam is now Buddhism and many of them also believe in the teachings of Confucianism and Taoism. All these religious affiliations have their roots in China (World Book Encyclopedia, 1992:411). According to Bennoun, Bennoun and Kelly (1984:51), the formal patterns of behaviour established by hundreds of years of Buddhist, Taoist and Confucian teachings have combined to produce a people who appear fatalistic and accepting. Such was the influence of the Chinese rule that can still be witnessed even until today.

According to Ow in Clare and Jayasuriya (1990:101) many Asian countries (including Vietnam) are very much influenced by Buddhist and Taoist beliefs and generally share these cultural traits:

- a. Group centredness is valued above individualism. They tend to be basically accommodating rather than assertive. They seek to receive

social support from family and kin, just as its ability to expect strength and support from these relationships in times of stress so that self and other relationships are built on networks supported by cultural ideas such as loyalty, filial piety, endurance and courage. Collectivism is evidently preferred to individualism. As Hsu in DeVos, Marsella and Hsu (1985:9) put it, the Chinese form of self-consciousness tends to be more interactionist than the Western form. It aims to transform the self into a totally social setting and is envisaged both as a centre of relationships.

- b. Wisdom is accorded to age. Older people are considered wise by virtue of the experiences they have had through the years. Their views, which must be accorded respect, applies particularly to intergenerational relationships. Filial piety, which is respect shown to the elders, is not the Asian parents' pathological exercise of power but should rather be perceived of as a way in which children could reciprocate their parents' love and efforts in bringing them up. According to de Souza et al (1998:42), this teaching is a direct influence of Confucianism in which children should love, respect and obey their parents for the sacrifices that they make in raising them. Yeo, S.S in Ferguson and Barnes, (1997:33) explains that for thousands of years, the concept of filial piety has been embedded in every aspect of Chinese life and society, and is to be found reflected in the customs and habits of the Chinese. The Confucian traditional book, 'Classic of Filial Piety' states that:

Our bodies, every hair and bit of skin are received by us from our parents This is the beginning of filial piety. It commences with the service of parents, it proceeds to the service of the ruler.

- c. Social harmony to be maintained at all times. Each individual is expected to act in a manner to attract harmony and peace. Conflict is often perceived as undesirable and would only be resorted to if there is no other choice in conflict resolution.

- d. A belief in the supernatural, portrayed of as either God, spirits, nirvana, enlightenment, heaven or reincarnation. In addition to spiritual benefits, it is also a functioning means for coping with stress and failures and for regulating excessive egotistical behaviour. Even in atheistic Confucian thinking, when all else failed, permission is given to the individual to attribute blame to 'heaven's will'.

This last trait exemplifies what Murdoch (1980) observes and that is, although the Western culture uses science and scientific method to provide exhaustive definitions and causes of illness, many other cultures attribute lack of good health to some supernatural causes:

'...that supernatural causes of illness far outweigh natural causes in the belief systems of the world's peoples. Especially prominent and widespread are in rank order, the animistic theory of spirit aggression, the magical theory of sorcery, and the mystical theory of retribution for taboo violations. Also significant, though with a more restricted distribution, are beliefs ascribing illness to the baleful influences of witches'.

In order to deliver an effective service, it is important to compare and understand the Western cultural self and compare it with the Eastern cultural self. This is because most mental health professionals in Australia are Westerners and are trained within a Western-based model institution. These comparisons have deep implications for health professionals in their service delivery.

Lutz and Obeyesekere, in Reid and Trompf (1990) contend that views of what constitutes a normal healthy body and person differ widely from culture to culture. For instance, while the Christians view the body as under the control of an independent self, the Buddhist self is indivisibly unified with nature, so that neither nature nor self is dominant. The self is more transient in the Buddhist view. To the Christians, the material world is concrete and factual, but illusory and ephemeral to the devout Buddhist. In the Christian's concept of the world, rational and analytic thought predominates, which for the Buddhist, the intuitive and synthetic (interrelated) are closer to his/her view of reality. In the Christian perception, the fundamental emotional state of the self is happiness,

which to the Buddhist, it is sorrow. These views confound the assumptions underlying notions of health and wellbeing in Western cultures, and in particular, the realm of psychiatric medicine (Minas in Read and Trompf, 1990:122).

Western philosophical thought has given much attention to the sense of alienation and loneliness, which are the pathological reciprocals of concern with freedom and individualism. In the Western preoccupation with the self, one finds often a sense of encapsulation and isolation, notably in the form of an estrangement from God or from a system of stable values, but also from other persons. There is a sense of being distanced from the environment and an emphasis of a concern with being 'rational', exemplified in Aristotelian logic (DeVos, Marsella and Hsu, 1985:14).

Individualism is much preferred among the Westerners than Easterners. When put to the test using Rotter's (Sue, 1981:75-76) concept of internal-external control or the internal-external dimension (I-E), the Asians scored the lowest in internality and the Westerners the highest. Internal control (IC) refers to people's belief that reinforcement is contingent on their own actions and that people can shape their own fate. 'External control' (EC) refers to people's belief that reinforcing events occur independently of their actions and that their future is determined more by chance and luck. These investigations have revealed that the 'individual-centred' Western culture emphasises the uniqueness, independence, self-reliance, individualism and status are achieved through one's own efforts. On the contrary, the 'situation-centred' Asian culture places importance on the group (an individual is always associated with the family), tradition, social roles, expectations and harmony with the universe. The cultural orientation of the more traditional Asian tends to elevate the external scores.

4.4.1 Four Main Aspects of Interaction Guiding Social/Cultural Behaviour

The relevance of discussing aspects of interaction guiding social/cultural behaviour is important because, according to Kiev in Blair (Radley, 1993:28) expressions of psychiatric disorders are influenced or shaped by culture. By understanding the social/cultural behaviour of the Vietnamese, one can minimise the misinterpretations of such behaviour which, consequently will help towards a more accurate diagnosis and treatment of mental illness among people.

Ow in Clare and Jayasuriya (1990:103) explains that there are four concepts which primarily guide the social/cultural behaviour of Asians and they are the concepts of 'place,' 'face,' 'self-control' and 'social influence':

a. Concept of Place

The positioning of the individual in an Asian family is formalised according to the circumstances of birth and not according to personal merit. This is regardless of capabilities and inclinations that that person may have. The individual is given a distinctive range of duties and responsibilities deemed right for his/her place, and the degree of power or influence depends on the nature of that range of duties and responsibilities. For instance, it is considered inappropriate for a younger person to question or argue with an older person as the older person is deemed to be in a superior position. This is in conformity with Confucius teachings as explained by Souza, et al (1998:42), in that children should love, respect and obey their parents and defying them is considered to be extremely bad manners. DeVos, Marsella and Hsu (1985:19) observe that Confucian thought exhorts one to realise oneself by keeping one's behaviour in accordance with the ideals of the family lineage.

b. The Concept of Face

Face-saving, contrary to popular beliefs that it only applies to Asians, is in fact, a universal phenomena reflecting good manners and a genuine concern for the feelings of the other party. What is distinctive about Asian face-saving, however, is that it also acts as a way of strengthening relationships between the self and others outside the immediate kin network. There are two main factors to this Asian concept and that is 'mianzi' and 'lien'. 'Mianzi' is equivalent to the prestige one obtains through success in life and 'lien' is the confidence society has in the integrity of the individual's moral character. Much of the social behaviour is dictated by the need to maintain 'face' in either one or both of these two aspects. Yeo S.S. in Ferguson and Barnes (1997:35) states that the honour of the family name is paramount, and all family members are expected to uphold the family honour so that the family does not 'lose face'.

c. The Concept of Self-Control

In keeping with the principles of Taoism, Asians are careful not to over-charge emotions, but rather, to express them in proper degree in order to maintain mental harmony. Emotions were seen to interfere with a person's ability to think logically and to make judgements objectively. It is believed that only when the senses are under control can the individual attain spiritual growth, freedom and ultimate liberation (Ow in Clare and Jayasuriya, 1990:108). According to Lao Tzu, the founder of Taoism, it is important to master the technique of mastering circumstances and not to try to control them. A follower is encouraged to work with their obstacles and problems instead of fighting at every turn. DeVos, Marsella and Hsu (1985:19) explain that all social harmony ultimately depends on self-regulation although the Confucian concept of self-development is the recognition of human frailty and fallibility.

d. Concept of Social Influence

The last concept is the impact of social influence on human behaviour. The dichotomy of good and evil as exemplified by the 'yin' and 'yang' in the Taoist theology, is common among Asians. This is clearly illustrated in Asian folklores, dramas and epics. While good always prevails over evil, the individual is expected to play an active role in overcoming evil by responding to good and bad influences appropriately.

In view of these discussions of the cultural self, Marsella in DeVos, Marsella and Hsu (1985:23) actually suggests a framework for conceptualising mental disorders to be based on the self. He argues that such a cultured-centred approach will provide an understanding of the patterning, classification and causes of certain mental disorders. To this end, he asserts that there is an intimate relationship between culture, self and mental disorders. To oppose this view implies a refutation of the critical role which subjective experience plays in human behaviour, and would in turn, reflect a limited and ethnocentric view of human behaviour. The self, therefore, emerges as a fundamental concept for understanding, describing, predicting and ultimately controlling human behaviour considered to be 'abnormal'.

4.5 HEALTH SEEKING BEHAVIOUR AMONGST THE VIETNAMESE

An understanding of the health seeking behaviour among the Vietnamese provides useful insight into their traditional treatment and consequently should assist Western mental health practitioners in their treatment of Vietnamese patients.

Kleinman (1986) observes that it is common for Chinese patients with psychological problems to seek care from a variety of health-care providers including traditional healers, naturalists and Western doctors. Such complex patterns of health-seeking behaviour have also been

described in the indigenous Vietnamese literature (T.Q. Nguyen and N.H. Nguyen, 1990). Traditional healers have been used by the Vietnamese for a wide range of physical and psychological problems. Only preliminary information is available on the use of these services by the Vietnamese in Australia (T.T. Phan, 1993). Until now there has been no systematic research investigating the levels of effectiveness or the popularity of these services. However, Sang in Minas, Lambert, Kostov and Boranga, (1996:153) observes that in Western Australia, traditional forms of remedy remain part of the widespread self-help practices and is used concurrently with 'orthodox' medicine.

The term "Thuoc Nam", which means Vietnamese medicine, encompasses practices that take into account a variety of substances, both organic and non organic. Herbal medicines are distilled from the various parts of plants, for example from bark, flowers, roots, trunks or leaves. Other parts of animals (for example seahorses, deer horns, tigers nails and bones, snake skins, livers and venom) have also been used. Thuoc Nam has been produced in and sold in various applications for example topical, tablets, syrups, wines or as food (Phan, Thuong, Silove et al, 1999:87). Thuoc Nam has always been an integral aspect of family life, with established prescriptions being handed down from one generation to the next. The origins of these prescriptions remain unknown. Such prescriptions detail not only the herbal composition but also the symptoms and signs of particular illnesses that are believed to be curable by the prescribed medicine. Although adherents of Thuoc Nam receive no formal training, traditional formulae guide the practitioner in identifying illness and preparing herbal medicines according to principles that have been used across many generations (Phan, Thuong, Silove et al, 1999:88).

"Thuoc Bac" means medicines that originate from the northern region of the South Pacific continent of China. There are many varied cults and traditions of practice which have evolved over the centuries and they range from naturalists who have no formal qualifications to practitioners who enrol for two to three years in more specified training programmes.

There are also physicians who complete six years of formal medical training. Thuoc Bac practitioners use a variety of medicinal substances which are similar to those used in Thuoc Nam (Phan, Thuong, Silove et al, 1999:88).

According to Hopkins, Nga and Linh (Multicultural Access Unit, year unknown) is the principle of Yin and Yang. According to this principle, health depends on a balance between the two basic principles of Yin (female, negative, cold) and Yang (male, positive, hot) and their interaction with the five basic elements of human being are composed - metal, wood, water, fire and earth. Health is maintained or restored through achieving a balance of 'hot' and 'cold' within a person. 'Hot' and 'cold' refers to the person's physiological state and not to their body temperature. Whereas 'hot' foods are used to treat 'cold' conditions such as the effects of birth, 'cold' foods are used to ease 'hot' maladies such as headaches, rashes and fever. Many herbal remedies are regarded as cooling, whereas Western medicine is generally regarded as 'hot'.

In addition to the above medicines the Vietnamese believe in cosmological readings. This method allows the practitioner to divide the aetiology, cause and outcome of illnesses by referring to various texts that are based on cosmological theory. Guidelines from the text are applied to assess the extent to which personal characteristics and environmental factors influence the onset and cause of the illness. For instance, diagnosis may be derived from diverse sources of information such as the time, date and year of the patients birth, the position of the persons house, bed or kitchen, the sites of the graves of immediate family members, and observations of the persons facial appearance, body shape, palms, soles and voice. Such information may be combined with documents derived from Chien Doan/Nghien Doan, a doctrine based on interactions between the planets and living things within the universe to establish diagnosis and appropriate treatment (Phan, Thuong, Silove et al, 1999:88).

The Vietnamese also consult other traditional health practitioners and these include witchcraft, spiritual blessing and sorcery. Practitioners can offer blessings of household articles and animals, for example, water and food, plus facilitating the healing qualities of the environment. Ritual activities are common for example ceremonies for expelling bad luck or mischance, repositioning a grave and adding a door or making a modification to an existing house. Praying and maintaining hospitable manners are also commonly recommended remedies (Ngo, 1991).

Western medicine was introduced into Vietnam under French rule. It did not supersede folk or traditional medicine. Rather, it is often used alongside with alternative medicine. Some Vietnamese, however, may never consult Western style practitioners and there are several reasons for this:

- a dislike of physical examination which can offend Asian modesty
- the unavailability of Western medicine in remote areas
- the fact that Western medicine is considered too strong for Asian constitutions (Hopkins, Nga and Linh, year unknown:8)

The wide diversity of treatments reflect the principles underlying notions of illness, namely, the holistic concept of mind and body and hence the appropriateness of combining physical and spiritual treatments.

According to Viet (Minas, 1996:2), there is only one large psychiatric institution in the South (Bien Hoa) and a few smaller ones in the North (Hanoi and Baegiang). These institutions usually treat patients with chronic, severe psychoses. Formal psychiatry was born with the establishment of the Hanoi Medical College Department of Psychiatry in 1957. Subsequently, some other similar departments were established in Thai Binh, Bae Thai and Hai Phong. From 1954 to 1975, the Mental Health Network gradually developed and eventually was integrated into the primary health care system. From 1975 onwards, there was further consolidation and strengthening of the Mental Health Network in the North as well as in the South. Vietnam now has six Departments of Psychiatry in medical colleges with the Mental Health Network having

375 district mental health clinics. These institutions and the network of mental health services are now working under the unified guidance and direction of the National Institute of Mental Health with respect to prevention, treatment, training, research and international cooperation.

4.6 CONCLUSION

The struggle for independence among the Vietnamese in Vietnam has carried undue and prolonged suffering that has lasted since the first foreign power came into existence until the fall of South Vietnam into the hands of North Vietnam in 1975. Never before had Vietnam witnessed such a multitude of its own people fleeing the country at risks to their own lives. The consequences of this prolonged war between North and South Vietnam were tragic. Those who did not get killed by pirates in their journey of escape found themselves confronted by a number of other challenges. Once accepted into Australia, their post-arrival experience was perhaps the most significant stage of their resettlement. During this stage, the difficulty of adjustments became realised as they embark on a long journey in a new country. Problems of unemployment, language difficulties, accommodation and the fragmentation of the family unit carried a lot of psychological distress for which they were unprepared. A discussion of the Vietnamese cultural self reveals a self that stands apart from a Western perspective. It clearly shows the differences between Eastern and Western thinking. Knowledge derived from this discussion is crucial to mental health practitioners in providing a service that can be seen as effective and meaningful to the Vietnamese. The health seeking behaviour amongst the Vietnamese clearly illustrates that traditional medicine had been extensively used in treating bad health. This also has a significant implication for practitioners treating Vietnamese clients suffering from torture and trauma.

Chapter 5

RESULTS OF FINDINGS

5.1 INTRODUCTION

Despite the generally high prevalence of mental illness in many CALD groups, psychiatric services are used by them at rates generally lower than those who are Australian born. Clinical staff working in State psychiatric services have expressed the opinion that the quality of services received by CALD groups is poorer than is the case for Australian born. The clinical outcomes are also considered to be worse (Human Rights and Equal Opportunity Commission, 1993:742). The mental health system is essentially monolingual and monocultural. As such, the structures, priorities and programmes do not reflect the diversity of the population. Both the dearth of assessment and treatment programmes designed to meet the specific needs of these people and the shortage of professionals with the necessary and appropriate cultural, linguistic and clinical competencies have rendered the system inaccessible and inappropriate to a substantial number of CALD groups in Australia (Minas 1990:250).

This Chapter aims to address one of the six objectives as outlined in Chapter One:-

- examine and critique barriers to accessibility and issues of cultural appropriateness within existing mental health services from a cross-cultural perspective.

In order to address this objective, the Chapter will be divided into two sections. Section One will describe and analyse the legislative policies under which the mental health system operates. Section two will describe and analyse Western based diagnostic instruments in relation to their content and linguistic validity and reliability.

The reason why it is important to highlight public mental health policies is because, according to Minas, Lambert, Kostov and Boranga (1996:71),

the important decisions concerning the provision of mental health services to the general community, are political decisions. Such decisions affect the allocation of resources for services and the priorities in these allocations, numbers and categories of professionals trained, training and skills required for these professionals, approval and regulation of forms of diagnosis and treatment, where such treatments can be carried out and so on. One of the measures of the success or failure of this process is the extent to which it results in services that meet the needs of the CALD communities. The extent to which the needs of minorities are considered and effectively responded to may be assessed as an indication of the majority and justice of the political system. The diagnostic tools of mental health service, are examined as a significant exemplar of a major method and tool of the mental health system in Australia.

5.2 THE LEGISLATIVE ENVIRONMENT - NATIONAL AND STATE

The Commonwealth Government has only recently entered, in the mid 1990's, the mental health arena. The outcome of which was the development of the National Mental Health Policy and a National Health Plan in 1992 under the National Health Strategy. Although the Commonwealth has been a major player in mental health for some time through Medicare funding of psychiatrists and GP's, the social security system and Commonwealth-funded disability programmes, the National Mental Health Policy and National Mental Health Plan has provided an opportunity to look into psychiatric system results as well as to bring some coherence to the provision of mental health services throughout the country. The delivery of these services, however, remains very much a State and Territory responsibility (Minas, Lambert, Kostov et al, 1996:74).

The National Mental Strategy sets directions for the reform of Australia's mental health services. Adopted by all Health Ministers in April 1992, it established a collaborative framework to help State, Territory and Commonwealth governments in carrying out these directions over the period 1993-1998. The National Mental Health Strategy's three main objectives are to:

- promote the mental health of the Australian community and where possible prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assume the rights of people with mental illness (Commonwealth Department of Health and Aged Care, 2000:6).

The National Mental Health Strategy is articulated in four major policy documents:

- The National Mental Health Policy outlines the approach to mental health reforms, promoting a shift from 'institutional care' to 'community care'.
- The Mental Health Statement of Rights and Responsibilities articulates the principles of United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness).
- The National Mental Health Plan provides an action plan for the period 1992-1993 to 1997-1998 and describes how Commonwealth, State and Territory governments would implement the aims and objectives of the National Mental Health Policy.
- The Medicare Agreements set out the Commonwealth, State and Territory roles in achieving reform of mental health services over the period 1993-1998 (Commonwealth Department of Health and Aged Care, 2000:8).

An independent evaluation was conducted for the first five years that focussed on the overall impact and outcomes of the National Mental Health Strategy. Although the evaluation concluded that the various State and Territory jurisdictions confirmed many examples of innovation and service improvement, the report also highlighted areas in which the Strategy has made very little progress or failed to deliver expected results (Commonwealth Department of Health and Aged Care, 2000:11).

This evaluative report's findings expressed concern that current services fell short of the Strategy vision for Australia. Service improvements were seen to be uneven across and within jurisdiction. For example, the issue of defining mental illness for legal purposes has been approached differently in various States/Territories of Australia. Definition of this term differs widely from State to State. For example, whilst the Western

Australian Mental Health Act of 1962 defines mental disorder as 'any illness or intellectual defect that substantially impairs mental health', and mental illness as 'a psychiatric or other illness that substantially impairs mental health', the Tasmanian Mental Health Act of 1963 does not even contain a definition of mental illness. It defines mental disorder as 'a mental illness arrested or incomplete development of mind, psychopathic disorder and any disorder or disability of mind' (Human Rights and Equal Opportunity Commission, 1993:42). In another comparison, while the New South Wales Mental Health Act of 1990 contains a relatively comprehensive operational definition of mental illness, the South Australian Mental Health Act of 1977 defines mental illness simply as 'any illness or disorder of the mind' (Human Rights and Equal Opportunity Commission, 1993:40-42). Many areas were yet to experience a tangible benefit from the National Mental Health Strategy reforms, an indication that the structural reform agenda was not completed. Concerns about poor service quality have only begun to be addressed (Commonwealth Department of Health and Aged Care, 2000:11).

Extending beyond the boundaries of the industry, primary care practitioners complained about the insularity of mental health providers in both the public and private arenas. They argued that not enough assistance was offered to them in alleviating the burden of mental health problems in the community which do not 'qualify' for specialist psychiatric care. In an evaluation conducted by Mihapoulos, Pirkis, Naccarella and Dunt (1999:48) on the role of general practitioners and other primary agencies in transcultural mental health care, many general practitioners have complained about the lack of policy directions to address the role that they have in the delivery of mental health services to members of CALD communities. Most felt that in the absence of such direction, there was very little likelihood of improvement. A participant was quoted as saying that:

'This issue cannot be left to the whim of particular individuals or agencies. It is something which requires coordinated affirmative action to really happen from both sectors, mental health and primary care. The Commonwealth needs to be involved because there is a shift in dollars from State/Territory to Federal funding.

The strategy which needs to be undertaken is to get all the stakeholders talking and to understand that the concepts and the issues involved in share care are not simple but quite complex and requires quite a lot of coordination, accountability and commitment to really get happening.'

The response from State/Territory Health Departments and the Commonwealth Department of Health and Family Services was an acknowledgement that the formation of partnerships (or share care) between general practitioners and mental health services is important. However, there is little direction from these departments as to how these partnerships should be formed. As a result, there is little evidence that integrated planning of service delivery is occurring (Mihapoulos, Pirkis, Naccarella and Dunt, 1999:49).

Under the National Mental Health Policy, some of the more important specific aims are to ensure consumers, carers, advocates, service providers and the community, that they should be aware of the rights and responsibilities. They should be confident in exercising them as well as to promote the mental health of the Australian community and prevent the development of mental health problems and mental disorders. In addition it also aims to reduce the impact of mental disorders on individuals, families and the community. Relevant to people from CALD backgrounds, this Policy explicitly recognises that there are groups in the community with special needs, stating that:

Mental Health Services systems should be responsive to the varying needs of particular groups. In some cases these groups will require specific services within the mental health system. It is important that mental health services be planned and delivered in a manner which is sensitive to the needs and expectations of different groups in the community (Minas, Lambert, Kostov and Boranga, 1996:74).

In addition, the National Policy affirms that a comprehensive mental health service system has some important characteristics. It needs to be adequately resourced and accessible to respond to the range and variety of needs of persons with severe mental health problems and disorders. The accessibility of services however, is dependent on a number of

factors and that includes the cultural appropriateness of the service itself and the skills of professional staff. The Statement of Rights and Responsibilities asserts that access to services should not be limited by 'cultural and ethnic barriers or by communication capacities and skills including language'. It has also included as a right that everyone should have access to 'appropriate and comprehensive information, education and training about their mental health problem or mental disorder, it's treatment and services available to meet their needs'. It went on further to recognise and state that individuals have the right to contribute and participate as far as possible in the development of mental health policy, provision of mental health care and representation of mental health interests. It also calls for the involvement of individuals in the planning, management and evaluation of mental health services as well as to communicate with health care providers in particular in decision making regarding treatment, care and rehabilitation. The Statement upholds the rights of individuals in their deliberations that 'all persons have the right to respect for individual human worth, dignity and privacy'. It went on further to say that individuals have the right to expect that preventative programmes be developed, implemented and evaluated as an essential component of all care provided for people at risk or suffering from mental health problems or mental disorders (Minas, Lambert, Kostov et al, 1996:76).

The National Policy extends such rights to service delivery when it says that:

The rights and civil liberties of people with mental health problems and mental disorders must be guaranteed and protected. Mental health services should be delivered in the least restrictive environment, with an emphasis on privacy, dignity and respect. Consumers must have access to information on their rights and to advocacy services to ensure their rights and to mechanisms for complaint and appeal (Minas et al, 1996:76).

The Commission in their assessment to determine the coverage of human rights of the mental health legislation of all Australian States and Territories, found fundamental inadequacies. It was assessed against the

international standards, (which were adopted by the Australian health ministers in 1991) and the United Nations "principles for the protection of persons with mental illness and for the improvement of mental health care". The assessment found that the legislation in every Australian jurisdiction contravened the United Nations standards in many ways and that in some jurisdictions, they actually breached the fundamental violations of basic human rights (Human Rights and Equal Opportunities Commission, 1992:1). The inability of Australian law to protect the human rights of persons suffering from mental illness is highlighted when it is the CALD individuals who are the focus of attention. For instance, the State and Territory Mental Health Acts are based on British legislation and modified to varying extents over the decades. For instance, although the Victorian and New South Wales Acts include some sort of recognition of the special needs and rights of CALD people the Mental Health Acts in all the other States are entirely inadequate in this regard (Minas, et al, 1996:72).

Under the Mental Health Plan the States/Territories were to report on the development of the most appropriate service models to meet the service requirements of identified special needs groups across different regions (Minas, Lambert, Kostov, 1996:74). These documents should provide a comprehensive framework outlining aims, policies and strategies for mental health services which are supposed to meet the needs and requirements of the general population. CALD people constitute a group which requires specific policy initiatives to ensure that their needs are ascertained, understood, and properly and effectively provided for (Minas, 1996:74).

State and Territory mental health policies set the guidelines for the organisation and management of the State mental health system, the resources allocated to it, and its priorities. Unfortunately, State mental health systems have moved almost entirely to the provision of services to only the most severely mentally ill. The resources have been allocated mainly in adult services with regards to the assessment and treatment of schizophrenia and other psychotic disorders, major effective disorders

and dementia, with, unfortunately very few resources being used for treating people with the vast array of other psychiatric conditions which are often no less disabling. The focus on the so-called 'seriously mentally ill' has caused very considerable debate and controversy. Other State policies which are equally important include recruitment and the constant resignation of staff, the setting of regional system boundaries, and so on. Such policies have an impact on whether the system remains a separate, relatively poorly funded, service or becomes part of the general system of health care. Any decisions made along these lines have a huge bearing in relation to the stigma which is attached to psychiatric services (Minas, Lambert, Kostov et al, 1996:73).

A Consultancy was carried out, as part of the National Mental Health Policy and Plan, to advise the Commonwealth Department of Human Services and Health on the development of nationally consistent mental health legislation. The purpose of this was to:

- maximise the involvement of the CALD community in their own health care, including the development and ongoing provision of programmes;
- establish a nationwide information network; and
- recommend on priorities to guide the allocation of National Projects funding for the years 1993-1994 to 1997-1998.

The Consultancy headed by Minas, Silove and Kunst (1993:5) found that in spite of the National Health Policy, there were major deficiencies in the current mental health system:

- inadequate mental health legislation and failure to implement existing policies;
- poor quality of service currently available to CALD communities;
- lack of involvement of CALD communities in design and evaluation of services;
- inadequate access by CALD communities to information;
- failure to adequately study stigma and to develop approaches for its diminution;
- inadequate education of mental health professionals;
- inadequate research;

- inadequate information about mental health status and mental health service needs of CALD communities; and
- inadequate information about patterns of service utilisation by CALD communities.

Policy arrangements, throughout the country, however, appear to be very inconsistent and have devoted little attention to the protection of the rights of CALD people with mental illness. They appear to overlook the broader picture and concentrate mainly on a few specific smaller objectives. For instance, in Western Australia, as in many other States and Territories, the emphasis was mainly on the encouragement of the utilisation of specifically trained interpreters and stressed the avoidance of unaccredited interpreters and only gave acknowledgement that services should be provided in a manner which is culturally and linguistically relevant to the requirements of a multicultural society (Minas et al, 1996:78).

The National Mental Health Report (2000:12) in its conclusion states that:

‘It is the view of the committee that much work remains to complete the mental health policy agenda commenced five years ago . . . many initiatives taken, particularly those focussing on service quality and outcomes, will not deliver results for several years and will need the momentum maintained’ (Commonwealth Department of Health and Aged Care, 2001:12).

The importance of effective government policies and legislations in ensuring an accessible and culturally appropriate mental health service can best be explained in the words of Tor Virchow, a renowned German physician, scientist and social reformer who lived in the first half of the 19th century. After a life of struggle and wonderful scientific achievements, Virchow concluded that:

‘Medicine is a social science and on the other hand politics is nothing but medicine on a grand scale’ (Jablensky in Ferguson and Barnes, 1997:11).

The ultimate aim of political decisions should be that they should take the mental aspect of people's lives into account and in this sense, Jablensky (Ferguson and Barnes, 1997:11) argues that they should be therapeutic.

Minas et al (1996:79) assert that these legislative arrangements within each State need to have a clear direction in the following areas in order to provide a more meaningful and culturally appropriate service:

1. Development of the means to ascertain the needs of CALD communities.
2. Development of the capacity to design, implement and evaluate innovative service programmes.
3. Recruitment of mental health professionals who are able to work effectively with people of CALD.
4. Training in cross-cultural clinical practice of all mental health professionals who come into contact with people of CALD.
5. Training and recruitment of adequate numbers of professional interpreters, and the training of professional staff in providing a culturally appropriate service.
6. Guidelines for the provision of services in a manner which is culturally appropriate.
7. Strategies for ensuring that services are accessible to people of CALD; appropriate community information and education programmes to make sure that CALD communities are aware of the services available and how to access them, and to reduce the stigma attached to mental illness.
8. Setting and monitoring of service standards.
9. Strategies for systematic service evaluation of the effectiveness and appropriateness of mainstream and specialised service programmes and that includes consumer satisfaction and service outcomes.
10. Appropriate data collection strategies.
11. Systematic strategies for ensuring that CALD community representatives are fully involved in the process of decision making in the area of service planning and evaluation (Minas, Lambert, Kostov et al, 1996:78-79).

5.3 CULTURAL/LINGUISTIC BARRIERS

5.3.1 Validity of Western Based Diagnostic Instruments

The influence of culture on psychiatric diagnostic assessment has always remained controversial. The tension arises because of two different viewpoints -the etic (empirical) and the emic (ethnographic) aetiological perspectives. The etic perspective argues that since there are universal core characteristics of human psychological functioning, Western-based measures therefore can be validly applied in the assessment of patients regardless of their culture affiliations. The emic approach asserts that diagnostic assessments must accommodate the sociohistorical and linguistic factors that influence psychiatric illness. To disregard this would result in ethnocentric bias (Phan, 1997).

Eisenbruch (1991:673) argues in favour of the emic approach and maintains that there are certainly pitfalls in the singular application of Western categories in diagnosing psychiatric disorders and distress among refugees. This diagnosis, which is a convenient one for mental health workers, picks up many people who have gross reactions that impair their psychological and social wellbeing. It offers a checklist of criteria, many of which have to do with physical changes in the body that are easy to elicit. It takes on the assumption that it occurs as a universal physiological reaction to stress and that the nature of the stressor or the cultural background make no impact. It is really based on a cultural view of health that prescribes how people should adjust or acculturate after immigration, how they should express their distress, how their orders should be classified and how the distress should be remedied. It seems to offer a universalist solution to a relativist problem. Health and illnesses are defined by culture and a psychiatric taxonomy must allow for variations in the cultural and linguistic background and the circumstances surrounding the trauma. Kinzie and Manson (1987:192) argue that it is important to recognise that the list of symptoms on a self report scale are

attempts to capture and categorise the ways that people experience or report psychiatric disturbances. However, different experiences and different languages may engender different manifestations of distress. The culturally restricted descriptions of illness represented in self-report scales severely constrain the clinician's ability to recognise mental illness in people from a different culture other than the one for which the scales were developed.

The DSM-111, the American Psychiatric Association's Diagnostic and Statistical Manual is the most common diagnostic instrument used among mental health professional all over the world. It has been criticised on many fronts. One of the more prevailing questions is whether any systems can be acceptable to workers trained in scientific method where diagnosis (for eg. schizophrenia) depend far more on the nationality of the person making the diagnosis than on any behaviour manifested by the patient. An experiment performed by Loring and Powell (1988) with psychiatrists to check the consistency in DSM-111 found that race and gender of both the psychiatrist and the patient had significant effects on diagnosis and that 'a false sense of confidence in objective measures can be dangerous when it ignores the possibility of bias (or misinterpretation) and specially so when it helps to maintain that bias through treatment and statistical reports'. (Jayasuriya, Sang, and Fielding, 1992:33). At this present stage, there are still no valid and reliable cross-cultural instruments capable of measuring torture, trauma and trauma related symptoms (Eisenbruch, 1991:673).

The diagnostic criteria of the DSM-111 can only be strictly applied when both the patient and the therapist who makes the diagnosis originate from the same Western background. Various researchers like Bleich, Garb and Kottler, (1986) and Solomon (1987) have concluded that the complaints and symptoms related to post traumatic stress disorders, and the way in which they are

represented may be influenced by the cultural background of the client. People from different cultural backgrounds experience and express their psychological problems and distress in different ways and it is difficult to identify the presence of mental illness and to reliably diagnose such disorder (Minas, Lambert, Kostov and Boranga, 1996:38). Definitions of 'normality', like definition of 'health' vary widely throughout the world. These definitions are based on shared beliefs within a cultural group as to what constitutes the ideal. These beliefs provide a series of guidelines on how to be culturally normal. Normality is usually a multi-dimensional concept. Apart from the individual's behaviour, the use of language, tone of voice, facial expression, gestures, postures etc. should all be taken into account in relation to their appropriateness to certain particular contexts and social relationships (Helman, 1992:215). This view of assessing 'normality' is indeed contrary to what Kiev in Helman (1992:221) propounds. Kiev's biological approach believes that the form of psychiatric disorders remain essentially constant throughout the world, irrespective of the cultural context in which they appear. For example, he believes that the schizophrenic and manic-depressive psychotic disorders are fixed in form by the biological nature of man, which the secondary features of mental illness, such as the content of delusions and hallucinations are, by contrast, influenced by cultural factors. This approach, however, has been criticised on many fronts primarily for the importance it gives to the Western diagnostic and labelling system.

These diagnostic instruments fail to take into account illness behaviour which is imbued in cultural symbols, values and beliefs. Very few Australian psychiatrists have the necessary expertise to take account of cross-cultural values at least when making a diagnosis. For example, a refugee from Vietnam who says that he 'hears voices' cannot be compared to a refugee from Eastern Europe who utters the same thing. In the worldview of a Vietnamese refugee, 'hearing voices' is more likely to be the

normal process of mourning. The Western psychiatrist may interpret it as hallucination. As a result, the psychiatrist may be more likely to diagnose it as the Vietnamese refugee having suffered from psychosis. In order to make a decision on treatment, the psychiatrist may conclude that the refugee is suffering from schizophrenia, a major depression with psychotic features, or is an aspect of re-experiencing which is an aspect of post-traumatic stress disorder (Rivero in der Veer, 1992:171). Kleinman in Helman (1992:221) has criticised the Who International Pilot Study of Schizophrenia in which schizophrenia was compared in a number of Western and non-Western societies. He points out that the fault lies in the study enforcing a definition of the disorder's symptomatology. By doing so, this definition may distort the findings by 'patterning the behaviour observed by the investigators and systematically filtering out local cultural influences in order to preserve a homogeneous cross-cultural sample'. By applying the Western model, Kleinman (Helman, 1992:222) argues that it is typical of what he terms as a category fallacy and is 'the reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established'.

Individuals from particular cultural backgrounds could be more likely to exhibit physical symptoms as a result of psychiatric disorder or psychological distress. This process which is known as somatisation can complicate diagnosis. Applying the DSM-111-R classification, for instance, to non-western patients in a text book fashion, may not only produce misleading diagnosis but also neglect other valuable behavioural and situational variables and observations that might shed light on the patients' emotional condition (Human Rights Commission, 1993:737). In another example, Waxler in Helman (1992:222) notes that in Western societies, social withdrawal, lack of energy and feelings of sadness are usually labelled as 'depression' while in Sri Lanka,

the same phenomena receive less attention and very little treatment.

Kahn (1986:47) in his observation of the problem of diagnostic classification of mental disorder, has this to say:

'Abnormal behaviour is largely a matter of deviation from a given culture's socially accepted norms of normality or actions. The norms vary from culture to culture. Cultural factors are also greatly involved in what appropriately stimulates emotion and how emotion is expressed. The DSM-111 is a Western classification system developed for a particular culture, and consequently, may have limitations when applied to other cultural groups.'

One good example of this sort of uniform and universal classification is the issue of depression. Contrary to the opinion of those who maintain that there is a 'core illness' of depression, it has been observed that the clinical picture of depression is a disorder of the Western world and may not be universal (Jayasuriya, Sang and Fielding, 1992:33). Marsella et al (1985:309) maintains that:

'The minimal requisites of a culturally relevant measure of depression include anthropological knowledge of a group's cognitive structure, including the experience and behaviour of clinically depressed individuals in different cultures; accurate translation of both the connotative and the denotative meanings of the instruments' contents; and the use of measurement formats that involve culturally appropriate scales, questions and parameters.'

In another striking example of the validity of using Western based instruments to assess mental disorders across cultures, Lutz as cited by Parsons (Read and Trompf, 1990:124) questioned the belief in the notion of 'the pursuit of happiness' that underpins many Western laws, policies and charters, such as the 'Declaration of Human Rights'. In this view, happiness is seen as the fundamental, normal healthy state of emotion and a state to be sought and achieved in life. Similarly, Obeyesekere challenged the

notion that happiness is the normative emotional state and that a 'prolonged state of sorrow' is a principle diagnostic symptom for the psychiatric label of a depressive disorder. According to the Buddhist teachings, Obeysekere explains that suffering, sorrow and a lack of pleasure with material things and human relationships are actually considered to be the normal state of emotion, and not happiness. Such studies question the validity of psychiatric labels given to emotional disorders. The Brown and Harris (1978) study on depression, which emphasised 'generalised hopelessness' as the key diagnostic criterion for psychiatric assessment, becomes problematic in the face of analyses such as Obeysekere's. It shows that in some cultures, such as the Vietnamese culture which has been profoundly influenced by Buddhism, these emotional states are positively valued as the basic anxiety in search for enlightenment. Kleinman cautions against what he calls 'the category fallacy' where scientific classifications of disease are no longer seen as social constructs contrived by and for Western societies alone, but are taken as universally valid classifications, independent of cultural bias, and are used as a standard by which to assess all other systems of knowledge.

On a more specific note, some of the errors that a clinician could make include the following:

- interpretation of culturally appropriate beliefs and behaviours as psychopathology;
- interpretation of psychopathology as culturally based beliefs or behaviours;
- failure to detect psychopathology;
- misinterpretation of the severity of psychopathology in either overestimating or underestimating the severity;
- incorrect classification of psychopathology and therefore, arrival at an incorrect diagnosis;
- failure to appreciate the significance of psychopathology to the patient and the patient's family (Minas, 1990:276).

Kendell in Helman (1992:225) adds to the list and cites the personality and experience of the psychiatrist, the length of the diagnostic interview as well as the styles of information-gathering and decision-making. Other factors like social class, prejudices, religious or political affiliations also have an impact on psychiatric diagnosis. Another factor is the diffuse and changeable nature of the diagnostic categories themselves. Kendell (1992:226) points out that many of these categories tend to overlap and ill people may fit into different categories at different times, as their illnesses evolve:

‘Many of these clinical features like depression and anxiety, are graded traits present to varying extents in different people and at different times. Furthermore, few of them are pathognomonic of individual illnesses. In general it is the overall pattern of symptomatology and its evolution over time that distinguishes one category of illness from another, rather than the presence of key individual symptoms.’

Cross-cultural self rating scales, as mentioned before, has been commonly described as ‘emic’ and ‘etic’. Originally, ‘emic’ is referred to the meaning that a particular cultural group attaches to a phenomenon whilst ‘etic’ is referred to a description of the phenomenon independent of any of the meanings a culture attaches to it. Over the years, however, this dichotomy has been mistakenly equated with culture specific versus universal, insider versus outsider and Western versus non-Western. This confusion has many clinicians describing many of the scales as ‘etic’ measures of psychopathology when in fact, no truly ‘etic’ self report measures exist because the respondent’s subjective sense of distress and their verbal report of that distress is very much based on his/her culture and language (Kinzie and Manson, 1987:192).

Overdiagnosis, underdiagnosis and incorrect diagnosis can all have a profound impact on the appropriateness of the treatment, advice given and its effectiveness and on the cause and outcome

of the patient's illness. Misinterpretation of cultural appropriate beliefs as psychotic phenomena may lead to unnecessary treatment with anti-psychotic drugs. This will lead to all the negative consequences of such treatment and the negative and social consequences of a psychotic diagnosis. Among the South East Asian refugees, such as the Vietnamese refugees, cultural norms like the influence of ancestors on current events and belief in the influence of spirits are sometimes misinterpreted as evidence of psychosis. The common expression of psychological distress in physical symptoms by many non-Western immigrants could lead to unnecessary, invasive and expensive physical investigations. It also prolongs and compounds the mental suffering and at its worst, risks suicidal attempts (Minas, 1990:276).

5.3.2 Issues of Cross-Cultural Counselling

Sue (1981) in Clare and Jayasuriya (1990:53) sets forth two propositions which he maintains underlie the efficacy of cross-cultural counselling:

- cross-cultural counselling is only effective if the practitioner and the client share the same world view. However, if this is not possible, the practitioner must be able to see and accept, non-judgementally, the legitimacy of alternative world views;
- cross-cultural counselling is more likely to be enhanced when the practitioner used modalities and defines goals consistent with the life expectancies and the cultural values of the client.

Meemeduma (1993:41) in her article on The Dualism of Oppression, argues that Australian social work practice do render the minority groups existing in Australia invisible simply by the fact that both practitioners and social workers do not see eye to eye because of the cultural barrier. Although she alludes this to the area of social work, the same problem can be present in other fields as well. She quotes Nobles as saying that conceptual incarceration exists when:

'The world view, normative assumptions, and referential frame upon which the paradigm is based, must like the science they serve, be consistent with the culture and the cultural substance of the people. When the paradigm is inconsistent with the cultural definition of the phenomena, the people who use it to assess and/or evaluate that phenomena become essentially conceptually incarcerated' (Meemeduma, 1993:3).

Through this conceptual incarceration, we will always render the cultural sense of other cultures invisible. By not acknowledging it and bringing it to the discussion table, we will contribute to reinforcing an ideology which contains elements of implicit oppression (Meemeduma, 1993:4). Rich in Meemeduma (1993:2) aptly sums up this mismatch of cultural values as:

'When someone with the authority of a teacher, say, describes the world and you are not in it, there is a moment of psychic disequilibrium as if you looked into the mirror and saw nothing.'

According to Sang in Clare and Jayasuriya (1990:42), it is not uncommon that counsellors or therapists espouse the notion that their work is an impartial helping profession. However, he refers to Casas (1984) as saying that the counselling profession is anything but impartial. Its core is formed by a fundamental set of values and ensuing assumptions which reflect the Judeo-Christian Western values of rugged individualism, competition, action orientation, progress and action orientation, the scientific method of inquiry, the nuclear family structure and rigid timetables. These values and assumptions are by no means universal. To subscribe blindly to them is to risk erroneous assessment and diagnosis and to invite disaster in the intervention. Sue and Sue (1977:426) further reinforces this assertion and explains that these values are contradictory to many Asian groups where they have been raised in an environment that actively structures social relationships and patterns of interaction. As discussed in Chapter 3, there are four aspects of interaction which dictate social behaviour among

Asians and they are the concepts of place, face, self-control and self-influence. All these four aspects have been dealt with in some detail in that chapter.

Further complications arise when counsellors/therapists, whilst acknowledging these cultural-bound values and assumptions, believe that they already have all the information and skills necessary for dealing with the clients effectively. Unfortunately, however, these assumptions and values are so inherent and pervasive that they operate unnoticed and unchallenged even by the most open minded professionals. The consequences of these unexamined assumptions are institutionalised racism, ageism, sexism and other forms of cultural bias (Sang in Clare and Jayasuriya, 1990:43).

Sang in Clare and Jayasuriya (1990:42) quotes Sue (1981) as labelling counsellors as 'perpetrators of cultural oppression' as many failed to acknowledge and remedy their cultural conditioning. In discussing the attitude of racism in counselling situations, Ridley (1989) in Sang (Clare and Jayasuriya, 1990:43-45) identifies seven counselling processes that hinder effective results for the members of CALD communities:

1. Colour Blindness

Colour blindness is an illusion based on the erroneous assumption that the patient from a CALD background is simply another client. The adverse consequence of this illusion is treating any deviation from the counsellor's standards and norms (usually white, middle-class) as proof of pathology.

2. Colour Consciousness

In contrast to colour blindness, it is assumed that all of the client's apparent problems stem from being a member of an ethnic minority group.

3. Cultural Transference

Developed from a Freudian idea, cultural transference refers to the emotional reactions (negative or positive) being

imposed on a client simply because the counsellor belongs to a different ethnic group.

4. Cultural-Counter Transference

Counter-transference refers to the emotional reactions and projections of the counsellor toward the client. As a result, the therapy becomes oriented towards treating the counsellor's projections rather than the client's real problems.

5. Cultural Ambivalence

Some counsellors exhibit a need for power and dominance while others show a high dependency in striving for the client's approval.

6. Evoking Pseudotransference

This is when the counsellor misinterprets the client's behaviour as a form of pathology when in actual fact, it is the client's defensive response to the counsellor's racist attitudes and behaviours.

7. Misinterpreting Client Nondisclosure

Clients may not self-disclose due to cultural and social factors. By disclosing, some client's may render themselves vulnerable to racism and misunderstanding.

Rogler, Malagady, Constantine and Blumenthal (1987) in Sue and Sue (1990:81) however, caution mental health practitioners on the credibility and validity of cross-cultural counselling. According to them, theories of counselling and psychotherapy attempt to outline an approach designed to make it effective, and they contend that cross-cultural counselling cannot be approached through any one theory of counselling. There are several reasons for this and they are:

- theories of counselling are composed of philosophical assumptions regarding the nature of 'man' and a theory of personality. These characteristics are highly culture-bound and what is the 'true' nature of man is a philosophical question;
- theories of counselling are composed of a body of therapeutical techniques and strategies. These techniques are applied to clients with the purpose of effecting change in either behaviours or attitudes. A counselling theory dictates what techniques are to be used and implicitly, in what proportions. Culturally different

clients might find these techniques offensive or inappropriate. The implicit assumption is that these techniques are imposed in accordance with the theory and not based on needs and values of clients; and

- theories of counselling have often times disagreed among themselves about what constitutes desirable 'outcomes' in counselling. For instance the psychoanalytically oriented counsellor uses 'insight', the behaviourist uses 'behaviour change', the client-centred person uses 'self-actualisation' and the rational-emotive person uses 'rational cognitive processes'. The potential for disagreement over appropriate outcome variables is increased even further when the counsellor and client originate from different cultures.

According to Stringer (1996:146) social reality is culturally constructed. It operates according to systems of meaning embedded in each cultural context and can be understood only superficially without reference to these meanings. It exists as an unstable and dynamic construction that is fabricated, maintained and modified by people in the course of their ongoing interaction with each other and their environment. If social reality is a cultural creation, then we can conclude that unless counsellors have the same cultural background as their clients, they cannot claim complete understanding and knowledge about how their clients think and operate.

5.3.3 Issues of Cross-Cultural Communication

Although there has been an increasing awareness that language and communication differences can impact on the way the health system operates, very little has been done to study how they affect the relationship between practitioners and patients. Again, this is partly due to the belief that the biomedical model of health care (predominantly a Western model) depends very much on a range of mainly physical procedures for eg, physical examination, physical manipulation, injections etc, rather than more communicative interactions between the two parties. Communications can also be influenced by patients having different cultural views on what constitutes illness and wellbeing

(Pauwells, 1995:3). Holding different beliefs may lead to patients having difficulties in conveying their problems even though they may be able converse in the same language as meanings of words change from one language to another in a literal translation. For instance, to express grief and disappointment, English speakers might tend to express it as 'I have a broken heart'. However, a Malay patient, if wishing to translate it literally, would end up saying 'My liver is broken', reflecting the status of the liver as the seat of emotions. It is commonly acknowledged that many second language learners have difficulties in learning the idioms, fixed expressions and metaphors of a second language (Pauwells, 1995:39). Differences in other areas like sounds, grammar, intonation, stress and rhythm make effective communication almost unattainable between the practitioner and the patient (Pauwells, 1995:35-41). According to Lee-Yuen Chinese clients are reported to have a tendency to somatise their health problem. The heart seems to be a 'favourite' organ to refer to as it is believed to be the centre of psychological functions. It is often used to describe emotions or used to refer to cognitive functions (Transcultural Mental Health Centre, 1997:17).

Blair in Radley (1993:28) quotes Szasz (1961) as contending that the very language of illness and disease has particular implications for the way in which distress is expressed and managed. He also quotes Warssman (1968) in arguing for the central significance of language in determining experience. Language, rather than simply serving to report facts, is viewed as a 'collective instrument of thought that enters experience itself, shaping and moulding the whole apprehension of phenomena'.

To throw more light on intercultural communication, Rutledge in Green (1995:298) explains that the idea of mental health is not even in the inventory of most Vietnamese and that the Vietnamese language does not have a direct translation of the term 'psychiatrist'. The formal term *bac si tam than* derives from a

Chinese word which means a doctor who treats the mentally ill and this does not make much sense to the Vietnamese. A Vietnamese physician was quoted as saying:

'You cannot talk about mental health. I know what you mean, but you will offend people (Vietnamese) if you use those words. In Vietnam, you are crazy if you have mental health (problems). You can be depressed, or lonely or afraid. That is okay, but you cannot have a mental health problem. Depression and mental health are not the same to Vietnamese'.

Counsellors who believe that having clients gain insight into their personality dynamics and who value verbal, emotional and behavioural expressiveness as goals in counselling are actually transmitting their own cultural values. For instance, comments made by mental health professionals that Asians are the most repressed of all clients is a clear indication that they expect their clients to exhibit openness, psychological mindedness and assertiveness. Such a comment may reflect a failure on the part of counsellors to understand the cultural upbringing of their clients. Traditionally, many Asian cultures value restraint of strong feelings and subtleness in approaching problems. Intimate revelations of personal problems may not be acceptable because such difficulties also reflect on other members of the families as well (Sue and Sue, 1977:425).

The cultural upbringing of the Vietnamese dictates different patterns of communication that may place them at a disadvantage as Western trained counsellors expect more communication from client to counsellor than vice versa. The client is expected to take a major role in initiating conversation. This expectation does not sit well with a traditional Vietnamese who have been raised to respect the authority and 'not to speak until spoken to'. Clearly defined roles of dominance and deferences are established in a Vietnamese family. Limited responses from the client may be interpreted negatively by the counsellor when in actuality, it is

probably a sign of respect for the counsellor (Sue and Sue, 1977:425).

Although language and cultural factors all contribute to create problems in communication, another often neglected area is that of non-verbal behaviour and conversation conventions. What people say and do are usually qualified by other things they say and do. A gesture, tone, inflection, posture or eye contact may enhance or negate a message. Raised in a white middle-class society, counsellors may assume that certain behaviours or rules of speaking are universal and have the same meaning. Personal space, eye contact and conventions regarding interactions are good examples (Sue and Sue, 1977:426).

5.3.4 Issues of the Use of Interpreters

It is highly unlikely that CALD patients are aware of their rights and understand the nature of their treatment when psychiatrists and other hospital staff do not know when or how to use interpreters. The failure to provide practice guidelines by health professionals across services to indicate how to use interpreter service and when it is necessary or appropriate, results in the onus for requesting them being placed on the CALD individual. The result may be that an individual who requires an interpreter to understand the psychiatric illness and the service system does not receive this information at all (Human Rights Commission, 1993:737-738).

The Inquiry into the Human Rights of People with Mental Illness frequently heard evidence that the medical team used other inpatients, family members and cleaners to interpret. Not only does this violate principles of privacy and confidentiality, but it may also mean that important decisions are based on inaccurate information-sometimes with life threatening results (Human Rights Commission, 1993:738).

Interpreters have a crucial role to play in the treatment process by bridging the communication gap between the patient and the psychiatrist. However, the issue is complex and needs to be carefully investigated. While qualified interpreters are proficient in translation and communication, their skills may not include familiarity with mental health terminology and other specialised psychiatric issues. The Inquiry was told that psychiatrists tend to over simplify the issues involved in treating people from CALD backgrounds.

On the other hand the presence of an inappropriate interpreter - no matter how proficient their linguistic skills are - may inhibit the development of a trusting client-patient relationship. The Inquiry was told that patients from CALD backgrounds will sometimes refuse to have an interpreter present during consultations because they know the individual concerned. This is especially so when it comes to a very small community and it is almost impossible to get an anonymous interpreter. In many cases the interpreter would know the patient and vice versa. The patients perceive that there will be talk in the community about their case. As stated earlier, people from CALD backgrounds can get stigmatised due to the nature of their mental illness. The psychiatrists in this instance need to be extremely sensitive and careful as to who the interpreter could be. The choice of interpreters may need to be decided by the patient himself or herself so that privacy and confidentiality can be maintained (Report of the National Inquiry into the Human Rights of People with Mental Illness, 1993:79).

5.4 CONCLUSION

Legislations pertaining to the Mental Health Strategy appear to be inconsistent and lack a definite focus and details about how culturally appropriate mental health services should be designed. The lack of a coordinated and well-planned approach has caused members of CALD communities to be dissatisfied with many aspects of the mental health

services. For instance, the use of standardised Western-based models of diagnostic instruments in assessing the mental health of CALD communities has been found to be clearly inappropriate and ineffective. Similarly, counsellors who are trained in Western institutions and who expound typically white, Anglo-Saxon values in their practice have not resulted in culturally meaningful outcomes for clients from CALD communities. The implications for all these is that the mental health system has been infiltrated with Western ideologies and consequently, needs a re-examination of the very fundamental structures that uphold these existing services.

Chapter 6

DISCUSSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In Jablenky's (Ferguson and Barnes, 1997:1) speech at a conference which marked the 90th anniversary of the emergence of the scientific discipline of cross-cultural psychiatry, he made reference to the wisdom of the German psychiatrist Emil Kraepelin. Kraepelin was the founder of modern psychiatry and the writer of an article entitled 'Comparative Psychiatry', which he wrote in 1904. This article laid down the fundamental principles of what we call today, cross-cultural psychiatry. The principles of cross-cultural psychiatry were inspired by a trip Kraepelin made to South-East Asia, in which he was convinced that the basic forms of psychiatric disorders could be found in different cultures.

Kraepelin (Ferguson and Barnes, 1997:1) argued that the systematic study of psychiatric disorders in different and contrasting cultures and societies would ultimately open the path to a better understanding of the universal features of the human mind in health and disease. This, in turn, would help enlighten our understanding and knowledge about the particular ways in which people belonging to a given culture develop psychiatric symptoms, express their suffering and can be treated. However, Kraepelin also foresaw major methodological obstacles to this pathway of study. He questioned the possibility of establishing diagnostic criteria and treatment for psychiatric conditions which were valid and reliable across different cultures.

In light of the above comments and in the results of findings in Chapter 5, the fundamental problem remains the cultural inappropriateness of the whole mental health system. It has placed obstacles to the correct diagnosis and treatment of clients' distress and disorders. This Chapter will focus on discussions and recommendations of how mental health practitioners can help remove these obstacles to ensure that their services can meaningfully and effectively service clients from CALD

communities. This is done through a discussion on how racism can effectively be addressed and how practitioners can cultivate an understanding and knowledge of cultural competence. These are crucial issues that need to be brought to the open. According to Minas, Lambert, Kostov and Boranga (1996:98), the most essential resource of the mental health system is really the cultural competence of its staff. This Chapter also suggests culturally appropriate ways of dealing with Vietnamese clients and discusses the effectiveness of some existing screening tools.

6.2 PAVING THE WAY TO A NON-RACIST APPROACH

According to Fernando (1991:51), although more recent Western psychiatry literature is less racially inclined, the racist tradition of Western psychiatry still continues in some current medical studies. For instance, the World Health Organisation perpetuates Western concepts of mental illness through studies like the International Pilot Study of Schizophrenia (IPSS), thereby undermining indigenous means of conserving mental health in Asian and African countries. As Western influence and economic power spreads universally, its ways of thinking about mental health/illness follow suit. There is no denial that regardless of the attempts made to shift the thinking to be more all-cultures embracing and universalistic, Western psychiatry is certainly here to stay and quite pervasively so. The cards are stacked against a remodelling of thinking to incorporate the wisdom and experience of non-Western cultures.

Against this background, Fernando (1991:170) argues that the pressing point that needs to be accepted if cross-cultural interchange is to take place, involves the need to counteract the forces of racism at all levels within the mental health system. This calls for an anti-racist approach in the evaluation of cultures and their constituents, whenever a mental health system is examined and evaluated. A revision of current thinking will most certainly challenge the cultural arrogance and racist ideology incorporated in many of the mental health/ill health assumptions of the West.

Strategies for changing attitudes and practices must be directed at the international and national levels as well as being concerned with changes at the personal (individual) level. Anti-racist strategies need to be devised worldwide and suited to each individual cultural situation (Fernando, 1991:201). The first strategy at an international level is to influence the World Health Organisation (WHO) to change its ways of working so that the alliance between WHO and Western economic interests may be broken. The practical projects undertaken by WHO in the mental health field should be aimed primarily at identifying and alleviating stress, rather than diagnosing and 'treating' mental illness based on Western concepts. Most importantly WHO must eliminate racial bias at all levels. This should be done with careful regulation of its research projects, selection of 'experts' who provide consultative advice and organise the delivery of services and the staffing of the organisation itself. It is essentially a political shift that is needed to begin with (Fernando, 1991:204).

6.2.1 Principles of Practice

As discussed in Chapter 5, the development of mental health services is influenced by Federal and State legislation and mental health policies. The question of power is therefore crucial. Fernando (1991:98) argues that a new approach to mental health must stand apart from the power structures. It has to acknowledge and truly embrace the fact that the majority of cultures in the world are neither culturally Western nor racially white. The influence and imposition of Western values on other cultures inevitably results in a superior-inferior cultural comparison. This must be addressed and overcome if mental health is to have a real meaning in all cultures and to people of all cultures and ethnicity.

The restructuring of mental health at a national and personal level must be concerned with developing a universal psychology that is sufficiently flexible and free of racism to understand mental and ill-health cross-culturally. The aim is not to build bridges between culturally distinct psychological-philosophical

systems that are forever separate, but rather, to evolve strategies to promote interaction (between cultures) that result in a better understanding on both sides. Cultures will be a part of that understanding on both sides. Mental health/ill health will be a part of that understanding and not something that divides people (Fernando, 1991:204).

The new mental health system, therefore, should ideally, extend beyond one discourse (Western) and embrace other cultural discourses as well. According to Welwood (1979) in Fernando (1991:205), he believes that a combination of 'the experiential, holistic, and enlightenment-oriented traditions of the East with the precision, clarity, scepticism, and independence of Western methods could lead to a new kind of psychology that transcends cultural limitations'.

This transcendence will help the mental health practitioner to study mental health/illness from a totally new perspective. For instance, people who hear 'voices' or have intensely meaningful experiences will not be diagnosed as 'hallucinated' or suffering from symptoms of 'passivity feelings'. Rather, it will be related to disturbances of balance within individuals, families and societies in a context of their relationship with the universe. Religion (which is an important aspect to be considered in the concept of mental health/illness in the Vietnamese culture), and psychiatry will not be considered as separate compartments, but one system that deals with all aspects of human existence (Welwood in Fernando, 1991:207).

6.2.2 Examination of Self

According to Minas, Lambert, Kostov and Boranga (1996:84), an important requirement for the development of culturally appropriate services at these levels is that mental health staff explicitly and critically examine their own assumptions and biases which form the culture of the professionals and the

services in which they work. Such an examination will help to gauge whether the professionals and the agency culture is appropriate to the target population and what else needs to be done. Similarly, the culture of the target groups should also be explored and examined. Some of the relevant aspects of cultures that need to be studied are outlined in this table:

Table No. 3

Aspects of community, professional and mental health service agency culture	
Beliefs	<ul style="list-style-type: none">- the causes and treatment of illness- what constitutes appropriate behaviour in the presence of illness- the nature of the relationship between patient and the professional, including respective power, rights, responsibilities and obligations- the role of family in dealing with and making decisions about illness and treatment-related matters
Values	<ul style="list-style-type: none">- individual/group oriented ways of defining self responsibility- the respective rights/responsibilities of the various participants in the illness experience
Practices	<ul style="list-style-type: none">- forms of address, which may indicate relative social position etc.- psychiatric illness
Attitudes	<ul style="list-style-type: none">- psychiatric treatment- roles of various professional disciplines

(Source - Minas, Lambert, Kostov and Boranga, 1996:84)

By studying these aspects of a culture, it will help the mental health practitioner respond appropriately to the presence of illness. It will also enhance understandings and improve relationships between both parties. Although there is an increased recognition of the cultural diversity of the Australian population, it has not been translated into a diverse range of

services that are determined by the needs of the communities that mental health services serve. Studying these aspects of the culture of the clients will help pave the way for innovation and experimentation that will only benefit both sides.

6.2.3 Incorporation of Tradition

The incorporation of traditional/cultural healing is a positive step towards paving the way for a non-racist form of treatment. To illustrate the significance of incorporating culture as a major part of the treatment, Lefley (Ferguson and Barnes, 1997:108) actually employed culture brokers in a treatment programme that he headed in Miami in Florida. The role of the culture broker is to facilitate understanding and utilisation of services by ethnic consumers within the context of their belief and value systems. Where diagnosis or treatment conflicted with cultural norms and expectations, culture brokers often arranged appropriate interventions. These included consultation or referral to a traditional healer or even arranging to exorcise a curse so that medications could take effect. As a result of these combination of approaches, programme evaluation actually demonstrated the efficacy.

Lefley (Ferguson and Barnes, 1997:108) cites Minas (1995) and states that so far, there has been no attempts in Australia to establish a dialogue between orthodox and traditional practitioners. The United States, as a comparison, have already attempted to develop syncretic rituals involving traditional healers. It is important to recognise the patient's etiology, especially when this perception may be a barrier to the effectiveness of neuroleptics. Williams (Ferguson and Barnes, 1997:54), in his address on traditional healers, indicates that there is evidence in the scientific literature that traditional healing techniques are effective in dealing with the following:

1. Neurotic disorders, including reactive depression, psychosomatic and somatiform disorders and psychosocial problems.
2. Reactive and transient psychosis, including psychosis-like, culture-bound syndromes.
3. Treatment, rehabilitation and prevention of alcohol and drug dependence. In this instance, therapeutic practices based on indigenous cultural and religious traditions, have, in many instances, been found to be as successful and in some cases more successful than 'official' programmes.

A relativistic approach towards 'Western' concepts about 'mental illness' would also be one of the major steps towards acceptance of traditional healing and improving communication with other ways of thinking. This would lead to a fluidity of thought about 'illness' that is culture-sensitive, flexible and most importantly, free of racist ideology. The final version is that a concept of illness will remain but it will be very different from the present one. It will also not be fixed in strict categories that can be universally applicable. Different societies will develop variations from one or more universal themes. Culture will form an integral part of the way that 'illness' will be defined and recognised. The explanatory models will vary with the culture and any one type of explanation will not be seen as superior or inferior when compared to other models. They will all be embedded within their cultures but understandable on the basis of universal themes. There will ultimately be diversity within unity and there will be a culturally relativistic view integrated into a universalistic approach (Fernando, 1991:201).

6.2.4 Cross Cultural Transfer of Western Techniques

If cross-cultural transfer of Western techniques of treatment has to be done, the present system of diagnosis and assessment in Western psychiatry has to be removed to reveal those aspects of psychiatry practice and theory that could be transferred. In the case of 'functional' illness, once diagnosis has been excluded,

knowledge about the personal distress and the evaluation of the disturbance can then be studied at a pragmatic level. The use of medication or other forms of 'treatment' can be examined. All treatment techniques must be seen as approaches to alleviate distress or particular forms of behaviour causing the problem. The important thing to consider is that the definition of the problem, behaviour or treatment must be assessed in a cultural context free from racist bias. The cultural context of all treatment must be geared to the culture of the individual client. It should be noted, however, that the experience of Western psychologists and psychiatrists in the application of broad principles can be useful in some situations if freed from racist value judgements (Fernando, 1991:175-176).

Fernando (1991:173) cautions however, that the question of extracting techniques is a complex and difficult matter for two reasons. Firstly, there is the problem of separating its form from its content. For example, does the technique of exorcism include all the rituals that usually accompany it or only some? Secondly, there is the problem of evaluating the effectiveness of the technique. As an illustration, the purpose of Western psychotherapy is conceptualised in terms of a person becoming self-reliant and independent. According to Hsu (DeVos, Marsella and Hsu, 1985:9), this is contrary to the Eastern idealism where individualism is not a desired trait but collectivism or group centredness is. In a survey conducted by Khalidi and Challenger (year unknown:26) on the mental health needs of CALD communities in ACT, an interviewee was found to have commented that:

'Many cultures arrive from a collective community, or a 'we' culture, where there is a sense of responsibility to others. The Australian (Anglo-Saxon) way of one of individualism, or an 'I' culture, based on individual rights, emphasising autonomy and independence.'

Mental health practitioners often make the mistake of using their own cultural values and standards, as a yardstick to measure the outcomes of the treatment.

In summary the step forward should see a cultural interchange for the treatment of mental illness. It should replace the 'unhealthy' tendency to impose Western ideas about how mental health/illness should be understood. It must embrace the client's concept of what causes the distress, how it is perceived culturally and traditionally and what treatment is considered effective by the client himself/herself.

6.3 CULTURAL COMPETENCE - A MAJOR STEP TOWARDS EFFECTIVE DIAGNOSIS AND TREATMENT

According to Ziguras et al, (2000:124) there has been a large body of literature on explanatory models of illness/treatment especially in the area of cross-cultural psychiatry. Both clients and mental health practitioners use explanatory models to help them in their conceptualisation of the illness experience. One of the most important elements in most of these models is the need for cultural competence on the part of the mental health practitioner.

According to Minas (Reid and Trompf, 1990:278), cultural competence is about the mental health practitioner achieving the following objectives:

- to gain as much as possible an understanding of the patient's illness in its family, social and cultural context
- to discern the patient's cultural values, attitudes and norms, in addition to eliciting the clinical history and identifying psychological symptoms
- to work as far as possible a cognitive framework that makes sense to clients and their families
- to avoid the common expectation among members of CALD communities that the mental health practitioner will regard their ideas about health and healing as ridiculous or stupid
- to avoid imposing on clients and their families a view of the illness that is culturally unacceptable

Likewise, Poole (Poole, 1998:163) argues too that to become culturally competent, one needs knowledge, skills, policies, research and values to work effectively. In addition, he asserts that cultural competence is really the ability to recognise the similar and distinct values, norms, customs, history and institutions of various ethnic gender and religious groups.

Lefley (Ferguson and Barnes, 1997:105) adds other factors towards achieving cultural competence. It involves first, an ability to interact with and be accepted by clients from CALD communities. It also involves the ability to elicit trust and induce the client to keep coming back and to develop treatment objectives that are appropriate and adaptive for the client's cultural background. Sue and Lane (1987) cited in Lefley (Ferguson and Barnes, 1997), maintains that cultural competence, however, does not necessarily involve the need to know everything about the culture. The important thing is that mental health practitioners must be perceived by clients as a credible source of problem-solving, with something of value to give.

Borkham and Meher's Development Model of Ethnosensitivity however, argues that cultural competence/awareness is actually limited to knowledge of individual's belief, values and practices (Campinha-Bacote, 1994). The authors assert that ethnosensitivity is a continuum where one moves from an ethnocentric perspective and works towards ethnorelativity. This involves placing the individual within the framework delineated by the individual. Seen from this perspective, cultural awareness is an ongoing process subjected to adjustments dictated by the client. Allison, Echemendia and Crawford (Allison, Crawford and Robinson, 1996) however, maintain that learning another culture through cognitive abilities does not necessarily translate to providing culturally sensitive care. Sensitivity is acquired more through exposure to diverse cultures rather than through cognitive abilities. Matsuoka (1990:101) maintains that applying such practice techniques as cognitive therapy responsibly requires a thorough understanding of the other person's worldview which clearly diverges from the Western sensibility. In this

instance, deeply ingrained superstitions about events beyond the individual's control are highly resistant to cognitive modifications techniques. This poses a challenge to Western medical practitioners whose Western-based training has not adequately prepared them for acceptance of alternative forms of treatment.

Meemeduma (1993) and Sue and Sue (1996) stress the importance of the practitioner being very aware of his/her own cultural values and bias as part of cultural competence. Unless one understands where one operates from, very little can be achieved in effective and meaningful cross-cultural interactions. This is because we operate from a very cultural worldview of our own and often make the mistake of judging others based on this worldview. Meemeduma (1988) maintains that understanding the notion of the cultural self is essential as what is thought, said and acted out is very much shaped by the prevailing concept of the cultural self as it manifests itself in the process of interactions amongst individuals.

Tilbury (2001:7) supports this argument by encouraging an examination of one's own biases, prejudices and stereotyping. Poole (1998) in Tilbury (2001:7) reiterates this stand and states that individuals need to assess their own socio-political-cultural agenda and central to this process is the ability to identify one's own cultural background and becoming exposed to other cultures. This interchange of cultures positively generates new skills and exposes one to be familiar with other worldviews. Ridley et al (Tilbury, 2001: 7) explains that it is a step towards readjusting previously held views in the light of new developments and shifting perspectives.

According to Minas, Lambert, Kostov and Boranga (1996:98) the most essential resource of the mental health system is the cultural competence skills of its staff. They need to have the necessary awareness, knowledge and skills outlined in Table No. 4 :

Table No. 4
The Skills Required by Clinical Staff

<i>Awareness</i>	<i>Knowledge</i>	<i>Skills</i>
<ul style="list-style-type: none">• Aware of his/her own cultural heritage and cultural values, assumptions, prejudices, predispositions, etc., and the range of cultural beliefs and practices in the patient's cultural group.• Aware of his/her own values and biases.• Comfortable with cultural differences in relationships.• Knows when to refer patients to professionals from the patient's own culture.	<ul style="list-style-type: none">• The demographic composition of Australian society and of the specific community which is served by the agency in which the professional works.• The circumstances of immigration of various groups (eg. refugees), the challenges of immigration and settlement, and the implications of these for general and mental health.• The effects of particular experiences (eg. torture and trauma) and circumstances (eg. settlement issues, unemployment, lack of English proficiency, etc.) on health and illness.• The sociology of minority groups.• The relationships between culture (our own general culture and, in particular, our specific professional culture, as well as the culture of the patient) and concepts concerning health and illness, and health practices.• The cultural aspects of the patient and his/her illness which may be relevant to assessment and management.• Institutional barriers to minority groups.	<ul style="list-style-type: none">• General competence in clinical assessment and treatment, and clinical communication.• Competence in communication in the cross-cultural clinical situation, including the specific skills necessary to work effectively with interpreters.• Competence in cross-cultural diagnosis, particularly in being able to properly interpret and evaluate the import of particular experiences (including symptoms) and behaviours in an appropriate cultural context.• Skill in engaging the culturally different patient in the therapeutic enterprise, in negotiating differences in concepts and interpretations, and in framing and communicating the therapeutic endeavour in a manner which is culturally appropriate and meaningful to the patient and his/her family.• Being able to advocate on the patient's behalf in his/her efforts to negotiate a health system which may be unfamiliar to him/her.

- Administrative skills which can be brought to bear on the agency or the broader health system in order to diminish barriers and improve accessibility and appropriateness of service structures and programmes to minority clients/patients.
- Teaching skills, which will enable the professional to impart the products of his/her learning and experience to students and colleagues.
- Research skills. The development of an attitude of curiosity and exploration in seeking to evaluate and improve one's own clinical performance, the quality of the service in which one works and services in general.
- The capacity to put aside, or at least on hold, one's own concepts, beliefs, etc. in order to attempt a genuine understanding of the concepts and beliefs of one's patient.

(Source: Minas, Lambert, Kostov and Boranga, 1996:98)

Cultural competence, in the text of the above table (Table No. 4) is not easy. However, unless one truly makes a genuine attempt to acquire the awareness, knowledge and skills, very little can be achieved in outcomes that are seen to be meaningful and purposeful by the client.

It is understood that different cultural groups vary in the specificity of their medical complaints, their style of medical complaints, their anxiety about the meaning of symptoms, their focus of particular organ systems and their responses to therapeutic strategies. It is therefore, sensible to

develop a meaning centred approach as proposed by Good and Delvecchio-Good (Tilbury, 2001) in which two fundamental principles override a traditional biomedical objectivist approach - that 'human illness is fundamentally semantic or meaningful' and that 'all clinical practice is inherently interpretive or hermeneutic'. A table of comparison of the biomedical and cultural hermeneutic models of illness is illustrated as follows:

Table No. 5
A comparison of the biomedical and cultural hermeneutic models of illness

Characteristics of the Biomedical (Empiricist) model	Characteristics of the cultural hermeneutic model
Pathological entity: Somatic or psychophysiological lesion or dysfunction	Meaningful construct, illness reality of sufferer
Structure of relevance: Relevant data those that reveal somatic disorder	Relevant data those that reveal meaning of illness
Elicitation procedures: Review of systems, laboratory tests	Evaluate explanatory models, decode semantic network
Interpretive goal: Diagnosis and explanation	Understanding (Verstehen)
Interpretive strategy: Dialectically explore relationship between symptoms and somatic disorder	Dialectically explore the relationship between symptoms (text) and semantic network (context)
Therapeutic goal: Intervene in somatic disease process	To treat patients' experience; to bring to understanding hidden aspects of illness reality and to transform that reality

(Good and Delvecchio-Good,1981:179 in Tilbury 2001)

To achieve a cultural, hermeneutic approach, Lefley (Ferguson and Barnes, 1997:144) actually lists the need to hire and train staff from relevant cultural groups in the population, as one of the factors that can help towards making the system more culturally appropriate. Considering the importance of understanding the client's cultural background as a fundamental prerequisite towards cultural competence, Lefley's point is a

sensible approach. Research into the effect of matching client's with the practitioner of the same cultural background has been found to be most beneficial. According to Ziguras et al (2000:21):

- It reduces drop-out rates;
- It increases the number of contacts with mental health services;
- It reduces contact with crisis centres;
- Many members of CALD communities prefer a practitioner of the same ethnic background;
- Employment of bilingual staff has led to increased rates of utilisation by CALD communities; and
- It may increase satisfaction with services.

6.3.1 Locating and Mediating the Role of Culture

In considering the significance and relevance of incorporating the understanding and knowledge of the practitioner and client's culture in this whole dynamics of diagnosis and treatment, Helman (1992) cautions practitioners in the danger of over-emphasising the influence of culture as an explanation for the client's behaviour and ignore any underlying psychopathology. In making cross-cultural diagnosis and treatment, the mental health practitioner should always be aware of:

- the extent to which cultural factors affect some of the diagnostic categories and techniques of Western psychiatry
- the role of the patient's culture in helping them understand and communicate their psychiatric distress
- how the client's beliefs and behaviour are viewed by other members of their cultural group and whether their abnormality is viewed as beneficial to the group or not
- whether the specific cluster of symptoms, signs and behavioural changes shown by the client is interpreted by him/her and by the community as evidence of a 'culture-bound psychological disorder'
- whether the client's condition is indicative not of mental illness but rather of the social, political and economic pressures on them

In spite of this caution, however, it is important that mental health practitioners are aware of their clients' cultural baggage. Affective and meaningful healing cannot be done from a vacuum. It is evident that culture has a place on how people see mental health/illness. The extent on which it influences people's perception on this issue is different.

6.4 TREATING THE VIETNAMESE REFUGEES - AWARENESS OF SOME SPECIAL SKILLS AND KNOWLEDGE NEEDED BY STAFF

The first stage in identifying a technique or treatment that is meaningful and makes sense to the Vietnamese refugees is to examine the Vietnamese culture and its approach to mental health. It must be understood and analysed from within its own culture as an outsider's point of view is likely to be contaminated by preconceptions about the culture and is usually based on racist ideas (Fernando, 1991:171). Chrisman (1991) in Tilbury (2001) maintains that a major hindrance to effective negotiation between the client and the mental health practitioner is medical ethnocentrism, where biomedical beliefs prevail to the exclusion of others.

6.4.1 Service Expectation

In providing a service to Vietnamese refugees, Kinzie et al (1990:1430) find it useful also to take a medical approach as well. This approach emphasises a thorough history of the client and concentrates on the development of the patient's symptoms, uses psychological interpretations infrequently and has the early reduction of symptoms as a goal. Kinzie and his colleagues' experience indicate that this medical focus is congruent with the Vietnamese's expectations about the behaviour of physicians. Western approaches such as questioning about feelings and sensitive relationships are culturally inappropriate and can be threatening. If 'talk therapy' has to be incorporated, Sang (1990:57) suggests that it is more effective if the practitioner is directive, works towards a specific goal and uses medicine. This is

usually interpreted by the client that the practitioner is in control and 'something' is being done.

Kinzie (1981:252) states that the Vietnamese refugee usually expects a rapid cure, an expectation based on contact with Western-trained doctors with their 'wonder' drugs. They may expect the practitioner to know the cause of the problem after only a brief history is taken. In fact, some have been very discouraged after seeing a number of physicians who have been unable to alleviate their symptoms. They are most likely to concentrate on physical problems especially those involving sleep, appetite and pain. Because of the respect they have for their practitioners they may be reluctant to describe their problems. As understood, there is a huge stigma attached to mental problems and there is a tendency to express psychological problems in physical form as heart trouble, stomach pain, 'weak kidney', 'hot intestine or liver'.

In line with how Lefley (Ferguson and Barnes, 1997:108) operates in his treatment programme in Florida, Rosser-Hagan and Nguyen (1988) suggest that the practitioner should liaise with ethnic leaders, monks, priests, elders or folk healers in order to use traditional techniques. This will provide credibility to Western therapy. In many cases, a simple ritualistic ceremony is all it needs to alleviate the client's suffering (Sang in Clare and Jayasuriya, 1990:58). Many Vietnamese believe that the cause of mental illness has either a natural, an animistic, a supernatural or magical explanation. These include being possessed by evil spirits, sinful acts that a person has done in the past, misdeeds committed by family members or being born at a bad astrological time (Lien and Rice on Thu, 1994:209-210).

6.4.2 Mistakes and Practice

In providing cross-cultural counselling, Johnson (1989:102) observes that some of the major mistakes that Western practitioners (and practitioners of ethnic origin who try to follow the

Western model) make when treating Vietnamese clients are as follows:

- Encouragement of verbalisation of feelings especially negative feelings. However, expression of such feelings are socially taboo in the Vietnamese culture. The ventilation of such feelings can be considered as rude or uncaring.
- Approach is likely to be passive, empathetic and non-directive. The Vietnamese patient expects authority and expertise from the practitioner and advice in the form of tangible suggestions and immediate tangible help are more likely to satisfy the patient's expectations and demonstrate the practitioner's authority on the matter.
- Expression of patient's need and meeting individual goals as paramount. Emphasis on individual needs are generally unacceptable. Suggestions to decrease individual distress that cause disintegration or bring shame on the family will only induce guilt in the patient.
- A 'professional' relationship to be maintained. This implies a degree of social distance between the client and the practitioner. The patient expects the practitioner to be personally interested in him/her. Personal interest from the practitioner will help overcome some of the taboos that one should not discuss personal affairs with strangers.

It is obvious that in this context of cross-cultural counselling, many practitioners make the mistake of assuming that their values and attitudes are universal. Unless the practitioner operates from the client's cultural worldviews, treatment will not convey a sense of relevance and meaning to the client. The challenge lies in distancing oneself from the dominant Western values that the mental health system operates within and placing oneself into another cultural domain which has relevance and meaning to the client, no matter how bizarre it may appear.

6.4.3 Appropriate Practice Principles

Sang in Clare and Jayasuriya (1990:57) cites Tung (1985) in offering the following suggestions when treating Vietnamese refugees:

- Expect understatement as grief and depression may be expressed with little emotion. Anger is often expressed obliquely and indirectly. Severe outbursts could reflect a serious degree of personality disorganisation.
- Modesty, discretion and self-depreciation should not be thought of as having low self-esteem. Easterners are often taught not to appear boastful or they may fear that what they express may have repercussions on their family.
- Family matters may be cause for even greater discretion especially when it concerns parents and elders. There is a lot of respect for elders.
- Sexual information can be very difficult to obtain as females may feel extremely uncomfortable when the practitioner is a male.
- Physical symptoms and bodily discomfort are more common topics for discussion. Sometimes strange sounding symptoms like 'hot liver' do not necessarily imply pathology.
- All symptoms should be examined in his/her own cultural context. For instance, talking with a dead person does not necessarily mean that the patient is running away from reality.

Lien and Rice (Thu, 1994:217) adds other suggestions in working with Vietnamese refugees:

- the client and his/her family should be told at the outset that the referral and treatment are confidential
- in the first few sessions, attempts should not be made to enquire too much about their personal history and their inner feelings. This can be seen as an intrusion. The focus should be on their general problems, complaints and demographic background
- they should be assured that any negative feelings towards their family members does not mean a lack of respect for them
- any expression of cultural beliefs and customs by the client should be acknowledged and respected by the practitioner

Cultural sensitivity is based on knowledge, mutual respect and acknowledgement of the cultural beliefs of the client. Once this is established, negotiation can be facilitated and treatment can be prescribed through mutual trust and respect.

6.4.4 A Way Forward - Cultural Healing and Traditional Treatment

In many cultures, ill-health is interpreted as indicating conflicts or tensions in the social fabric. Kleinman (Helman, 1992:239) uses the term 'cultural healing' when healing rituals are used to repair social tears and to reassert threatened values and arbitrate social tensions. The aim of treatment, therefore, is to resolve the conflicts causing the illness, restore group cohesion and integrate the patient back into his/her cultural environment.

Lien (Minas and Hayes, 1994) relate how Vietnamese perceive mental illness/disorder not so much as manifestations of illness, but rather as a predicament or punishment in which they have to repay either for the misdeeds of their ancestors in the past or misdeeds in their previous lives, being possessed by malicious spirits or the casting of magical spells by a sorcerer. According to Lien and Rice (Thu, 1994:210), a popular belief is that the cause of psychosis is due to a person having a black magic spell cast upon him/her. The black magic spell can be cast by a malevolent person, a magician or a sorcerer. It makes the victim lose his/her mind and is considered to be 'mad' by the community. By seeking traditional and culturally meaningful treatment, which in this case is to seek spiritual healers to perform rituals to exorcise the spirits, they would be ensured of forgiveness for their 'sins'.

Eisenbruch (1992:10) explains that the healer makes a diagnosis not by grouping symptoms or, for that matter, other characteristics such as the organs affected. He heals the client by metaphorically entering the world of the client's terror or distress and identifies the whole spiritual and somatic mechanisms by which the client feels his/her afflictions. The healer then deals promptly with the cause. Hopkins, Nga and Linh (Health Department of WA, year unknown) state that horoscopes, divination and fortune theory are also consulted upon to provide guidance for behaviour and acceptable explanations for problems, thereby alleviating anxieties and

making difficulties easier to cope with. Through this process, the 'mentally ill' person is reintegrated into society. According to Waxler' (Helman, 1992:239), this process, together with the care of family members, may mean that in a traditional Vietnamese society, mental illness could be more easily cured and much more shortlived than if it was treated under a Western tradition.

An example of how widespread is the use of traditional treatments by Vietnamese refugees in Western Australia is shown in a research funded by the Western Australian Heart Promotion Foundation (WAHPF) to investigate how members of the Vietnamese community in Australia achieved the following objectives:

- perceive and conceptualise physical and mental health/illness;
- understand the causes of physical and mental health/illness; and
- select and utilise helping systems for example, Western versus traditional (Sang in Minas, 1996:153).

Findings from this research are that many Vietnamese adopt models of health and illness which contain culturally shaped notions of aetiology (Sang in Minas, 1996:153). The research also reported that patterns of help seeking practices appear to be drawn towards traditional forms of remedy usually conducted in their homes and this is usually practised concurrently with orthodox medicine (Sang in Minas, 1996:154). To do this, the healer links the properties of each distress with the intent attributed to it. Some mechanisms or treatment are used only for a specific type of invading spirit causing the distress, others are used for several. The treatment takes on its meaning according to the idea of the underlying spirit cause.

Traditional Vietnamese treatment is based on the key principles of Yin and Yang. Health is dependent upon a balance between these two basic principles and is derived from Chinese medical theory.

Yin (or Âm in the Vietnamese language) is the female force and represents negative energy that produces darkness, cold, wetness and emptiness. Yin (or Dương in the Vietnamese language) is male and represents positive energy which produces light, warmth, dryness and fullness. The balance of Âm and Dương results in good health (Lien and Rice in Thu, 1994:210).

Weak nerves are commonly used as an explanation for mental illness. Vietnamese believe that the nervous system is the source of all human activities, particularly mental activities. The level of these activities can change once the function of the nerves is disturbed (Lien and Rice in Thu, 1994:210).

Knowledge about the causes of mental illness from a Vietnamese point of view is a key factor in determining the treatment. Providing treatment from a Western model will not be effective and will only cause further stress and frustration on both parties.

6.4.5 Case Studies

Lien and Rice (Thu, 1994:215) relate a case of a Vietnamese patient who held strong cultural beliefs relating to his mental illness. Mr X, a 40 year old married fisherman was referred to the mental health service because he complained of 'confusion in his head, insomnia, repeated dreams of his deceased sons, aggression and poor appetite'. He attributed his illness to many factors. Four of his relatives (his two sons, an uncle and an older brother) were drowned at different times but within a space of six years. Two of these years were considered as the Year of the Rat according to the Chinese Zodiac. He considered the Year of the Rat to be particularly unfortunate for him and believed that it was his family's bad karma. He also believed that he and his family had to suffer because his ancestors spirits were not worshipped properly. In addition, his grandfather died at an astrologically bad time called 'ngày trùng' which means 'repetitive death on the same

date' and he also believed that his house was built in the wrong direction.

Apart from seeking treatment in the mental health service, he also sought advice from spiritual healers to improve his situation. He was advised to move his children's graves in Vietnam to a higher position so that they could lie peacefully in their graves. He was also advised to perform a solemn ritual of offering to the spirits every four years to ensure that bad things will not happen to him. As a result of doing what he was asked to do, he became better. Although this may sound bizarre by Western-trained practitioners, the fact that he was not ridiculed by them had actually helped him in his recovery process (Lien and Rice, 1994:216).

The relevance of this approach is also highlighted for other South-East Asian refugees. For example, in another case, Eisenbruch's treatment of a Cambodian refugee will also illustrate how a culturally appropriate approach has effectively alleviated the suffering of his client. Eisenbruch's (1991:675) experiences with Ros, a refugee in Australia, illustrates how a refugee can think, feel and act in ways that express her cultural bereavement, but be wrongly diagnosed as having a psychosis or a post-traumatic stress disorder.

According to Eisenbruch, cultural bereavement is defined as the experience of the uprooted person resulting from the loss of social structure, cultural values and self-identity. The person continues to live in the past, is visited by supernatural forces from the past while asleep or awake, suffers feelings of guilt over abandoning culture and homeland, feels pain if memories of the past begin to fade away but finds constant images of the past (including traumatic images) into daily life. Yearnings to complete obligations to the dead, feeling stricken by anxieties, morbid thoughts and anger which mar the ability to get on with daily life is quite

common. It is not of itself a disease, but an understandable response to the catastrophic loss of structure and culture.

Since the birth of her youngest child, Ros had felt worried, depressed and troubled by dreams in which she saw horrifying figures that told her to harm her son. This frightened her terribly when she was alone in her flat. She missed the family in Cambodia and had 'scramay'. This is the 'cuo cambuo', which is derived from the mother and father. It protects her against danger but when provoked, can cause harm. She was observed to be crying and complained of blackouts, shortness of breath and tingling extremities. The health team diagnosed post-traumatic stress disorder and post-natal depression with psychotic features, and it was thought that she might be a child abuser and that Oak, her child, should be taken away from her.

An examination by Eisenbruch (1991: 679) showed that Ros was frightened because she felt that she had not made merit to her ancestors and because of that, her parents' spirit would return to hurt her. She was also troubled by evil spirits coming to hurt her child because his birth was induced and his placenta thrown out by the obstetrician. The induction of labour meant that Oak was born on the wrong day and the placenta not properly disposed of. If the child had been born in Cambodia, the placenta would have been buried to prevent the spirits from smelling the blood and killing the child, thereby making her sick. She had witnessed 'bright green lights' flying through the neighbourhood and she had been overcome by an icy feeling that these were the spirits coming to do harm to her.

Instead of attempting to treat her in the normal western obstetric routine, Eisenbruch (1991:679) took her, at her request, to seek help from a traditional Cambodian healer. The 'kruu' or traditional healer, diagnosed her as suffering from 'priety', 'boysaac' and 'neak taa'. It was also found that Ros's date birth was in decline

and that the 'cuo cambuo' on her father's side was angry with her. The 'kruu' treated her and her child with several ritual ceremonies to expel the evil spirits and place a protection marker around her house. After this ceremony, Ro's bad dreams stopped and her physical symptoms subsided. Both mother and son began to thrive (Eisenbruch, 1991: 767).

This episode illustrates clearly that in order to effectively treat the patient, it is essential that the health professional operate within the cultural setting of the patient. The 'kruu' had turned an unhealthy contact with the past into a mastery of the separation from home and the symptoms of post-traumatic stress disorder abated. Her cultural bereavement was acknowledged by the western practitioner who, instead of trying to suppress her visions of her family at home and the associated vengeful spirits, 'protected' her by allowing her to believe what she thought had caused the problem and complied with her wishes to consult with her 'kruu'.

6.5 DISCUSSION AND RECOMMENDATIONS FOR CULTURALLY APPROPRIATE SCREENING INSTRUMENTS

It is acknowledged that the Western illness classification systems and screening instruments are not culturally applicable to all cultures. Much has been researched in validating a cross-cultural instrument to measure torture, trauma and post-traumatic stress disorder among refugees (Mollica, Wyshak, DeMarneffe, Khuon and Lavelle, 1987:497). Existing tools are being trialled in a variety of different cultures and new tools are often being developed for specific groups. For instance, in 1994, the Diagnostic and Statistical Manual (DSM-IV) was modified to include cultural factors to incorporate the role of culture in psychopathology. Castillo in Tilbury (2001) explains that three factors were included into the DSM-IV and they were:

- how cultural factors can influence the expression, assessment and prevalence of specific disorders;
- an outline of a cultural formulation of clinical diagnosis to complement the multi-axial assessment; and

- a glossary of relevant cultural-bound syndromes from around the world.

Like many of the instruments, however, the DSM-IV has its limitations. According to Lopez in Tilbury (2001), it fails to provide a thorough discussion of the crucial role that culture plays in psychopathology. Lopez argues that the limited discussion of specific symptoms which can be both culturally normative experiences and signs of distress, and the placement of cultural bound syndromes in the appendix, tend to exorcise the function of culture.

The DSM (of which the DSM-IV is a revised version) has been used as a standard reference for many mental practitioners in many countries. Unfortunately, it offers a checklist of criteria, many of which have to do with physical changes in the person's body that are easy to identify and are presumed to occur as a universal physiological reaction to stress. The nature of the stressor or the cultural background makes no difference. It is based on a cultural view of health that prescribes how people should adjust or acculturate after immigration, how they should express their distress, how their disorders should be classified and how the distress should be remedied. It seems to offer a universalist solution to a relativist problem (Eisenbruch, 1991:673).

Eugene Brody (Eisenbruch, 1991:673) in his critique of the DSM, states that this diagnostic tool contributes to a worldview that values biology over culture. It does not even have the term 'culture' and is only mentioned in passing in the revised version (DSM-111).

6.5.1 An Alternative Instrument

Among the screening instruments, Mollica, Wyshak, DeMarneffe Khuon and Lavelle, (1987:497) advocate for the Indochinese version of the Hopkins Symptom checklist - 25 (HSCL-25) as one of the more culturally appropriate tools for the Vietnamese refugees. It has been found that the HSCL-25 has several advantages as a screening instrument for them as the

questionnaire is brief and simple in its language and could be self-administered by literate patients. According to Kinzie (1981:252), Indochinese refugees are reluctant to describe their problems due to a number of reasons -

- the stigma and social consequences of insanity in their own culture
- the very justified fear that if mental illness is diagnosed they will be denied permanent visa status
- the respect to the practitioner
- they do not want to be seen unappreciative to the host country

In view of these reasons, the Vietnamese refugee is reluctant to express their distress. Whilst other instruments can be very comprehensive and emotionally intensive as to be capable of triggering flashbacks and cause emotional reactions, the HSCL-25 is a short non-provocative instrument that puts words around the patient's feelings (Mollica, Wyshak, DeMarneffe, Khuon and Lavelle, 1987:489).

The HSCL-25 has several advantages as a screening tool for Indochinese refugees and is extremely helpful in the clinical setting. Mollica, Wyshak, DeMarneffe, Khuon and Lavelle, (1987:489) states that because the questionnaire is brief and simple, it can be understood by people of all levels of educational attainment. While the HSCL does not supply a diagnosis, it allows the clinician to recognise symptoms universally associated with anxiety and depression. The four categories of response, ranging from 'not at all' to 'extremely', provide a safeguard against simple 'yes' and 'no' answers. The items are neither seen as questions nor true-false statements. This structure is helpful in determining the severity of a psychiatric disorder and in documenting change in the patient's condition.

The HSCL-25 has been able to move beyond 'just not feeling right' in order to specify emotional complaints necessary for diagnosis

and treatment. It has been useful for these Vietnamese refugees as many are very shy and reticent that they find it hard to articulate their major psychiatric symptoms. It is also more readily acceptable by the patients as it resembles a medical test and easily understood by paraprofessionals. By doing so, it allows them to retrieve information about psychiatric symptoms that they generally consider as restricted to the sphere of medical professionals.

HSCL-25 was developed under one of the national projects at the Indochinese Psychiatry Clinic in Massachusetts. It is a well known and widely used instrument that dates back to the 1950s. For the Indochinese version of this tool, semantic equivalence was established in accordance with the guidelines of M. Gavira et al, which are generally accepted in the field of cross-cultural instrument development. Gavira et al, note that 'the development of equivalent measures of the same instrument in several languages requires more than mechanical translations, it requires similarity in regards to style and connotation. They stressed the importance of collaboration between indigenous professionals and Western trained clinicians through such means as expert panels, 'back-translation' and establishment of methods for resolving differences (Mollica, Wyshak, DeMarneffe, Khuon and Lavelle, 1987:489).

It is an admittedly difficult task to examine which instrument is more appropriate to which culture. Ridley (Tilbury, 2001) however, has proposed 11 key principles which any instrument must adhere to in order to capture the cultural meanings of the client:

- The use of emic criteria, that is the conceptualisation of mental health functioning from the perspective of the client's indigenous culture instead of from that of external cultural standards;
- The use of standardised instruments in culturally appropriate ways. This includes awareness of bias in content, language, samples, test-taking skills etc. Practitioners should be engaged

in culturally sensitive testing by incorporating other relevant information into their interpretation of test results. Other alternatives are to use non-standardised methods, culture specific instruments or the DSM-IV with cultural sensitivity. The conduct of a behavioural analysis is also mentioned;

- Assess the client's psychocultural adjustment;
- Clarify the purpose of assessment;
- Interpret culturally related defences;
- Negotiate the explanatory model so that a mutually interpretable explanation for the client's presenting problem can be achieved;
- Consider alternative explanations as well as interpretations of behaviour;
- Establish credibility by validating the client's cultural belief system;
- Use a broad based assessment strategy;
- Use interpreters and translators; and
- Involve the family network.

In summary, a large variety of screening instruments have been designed and many of these have been translated into a variety of languages. Although some have demonstrated reliability, many have been repeatedly criticised for lack of accuracy. Very little exists in evaluating the effectiveness of these tools. The important thing is to continue to improve and evaluate on existing screening tools so that diagnosis and treatment can be conducted in a culturally sensitive manner. Ridley's 11 principles should serve as a guide in devising an instrument which aims to make cultural sense and prove meaningful to both parties.

6.6 CONCLUSION

in cross-cultural psychiatry, it has been shown that mental health has many meanings and its maintenance not only encompass medical factors, but also religious, ethical and spiritual dimensions. While ideas about mental health are largely determined by culture, racism has coloured Western concepts about people originating from other cultures. Racism, undeniably, is one of the main reasons why mental health services are not sufficiently accessed by members of the CALD

community and why many of them have not received culturally meaningful and effective treatment. To provide for a culturally appropriate system of mental health care, racist preconceptions of cultural forms and habits must be challenged. This demands an honest approach towards developing a non-racist view of cultural, religious and medical practices within the existing system.

All literature has advocated for practitioners to be culturally competent for them to be effective in dealing with members of CALD communities. They need to gain a sound understanding and knowledge of the cultural background of their clients. There have been several models designed to help the practitioner in ensuring a more purposeful outcome. The important point that has been stressed by most of these models is that in general, it must be client focussed and dictated by the culture from which the client originates.

Similarly, there has also been a number of screening tools to facilitate the client's explanatory model of illness. Although some have proven to have some level of reliability, many fail to prove their cultural competence. There is a need, therefore, to continue to re-assess these tools and to further design more appropriate ones. The overall aim will be that all explanatory models will incorporate culture and any type of explanation must not be seen as superior or inferior as compared to others. As Fernando (1991:201) puts it, they will all be embedded within own cultures but also based on universal themes. There will be a diversity within unity, that is, a culturally relativistic view integrated into a universalist approach.

Chapter 7

SUMMARY AND CONCLUSION

Australia's multicultural population have aroused considerable interests among health and medical practitioners on cross-cultural issues of mental health/illness and the psychosocial effects of immigration on mental health. The steady flow of migrants and refugees from a diverse range of cultures since World War II has also highlighted the issue of how culturally accessible and appropriate is the Australian mental health system.

It is widely acknowledged and documented that although there has been continued interests shown by policy makers and mental health service providers, on how effective the mental health system is in delivering its services to people from CALD communities, the problem still persists in the fact that it is underutilised by these people. Compared to the Australian-born and those who are Anglo/Celtic migrants, it was found that they take longer to receive psychiatric treatment and have the tendency to receive help mainly from family members or traditional healers.

There has been many factors which prevent CALD communities from utilising these services. Broadly speaking, it lies in the fact that perceptions held by CALD communities about mental illness, significance of symptoms, desirable patterns of care and role of health workers are not usually shared by mental health practitioners. Thereon lies the mismatch between the ideals of both sides with respect to how to address mental illness/disorder among members of CALD communities. This research argues that this mismatch could have been more effectively addressed if not for cultural racism that has underpinned the fundamental structures supporting the various models of service delivery. Cultural racism is about placing more credibility and value on those beliefs and ideas endorsing the superiority of white Anglo-Saxon culture.

Against this monocultural system of service delivery, it is no wonder that the Vietnamese community is found to be one of the least likely to access these services. The dominant Anglo-Saxon philosophy and ideals, which are deeply entrenched in its structures, priorities and programmes of the mental health

system has not projected the cultural diversity of the population that it has a responsibility to serve. Racism has been socially constructed over hundreds of years and its origins have been lost in the history of Western culture.

To address this problem, it was necessary, first, to discuss certain fundamental concepts that form the background of this research. Concepts of culture, mental health/illness discussed within a cross-cultural perspective has given an insight into how people from different CALD communities perceive and treat mental health, in particular, the Vietnamese community. An understanding and knowledge of the social, historical, political and cultural background of the Vietnamese is also included in this research. This is crucial towards paving the way for a culturally appropriate mental health care.

More detailed examination has shown that deficiencies within the mental health system exists in many areas. These areas range from the failure to formulate adequate mental health legislation by the government, the failure to implement existing legislation, to inadequate information about mental health status and mental health service needs of CALD communities. Decisions concerning the provision of mental health services affect the allocation of resources for services. The priorities in these decisions, such as training and skills required by mental health professionals, approval and regulation of forms of diagnosis and treatment, where such treatments can be appropriately delivered are all important issues currently inadequately addressed within the Australian mental health system.

Racism within the existing mental system has been identified as one of the main causes of the failure of the system to provide a meaningful and culturally appropriate service to CALD communities. In order to address this problem, racist conceptions of cultural forms and habits must be challenged. It demands an honest approach which leads to the inclusion of non-racist options of cultural, religious and medical practices all over the world that is to do with preservation and maintenance of mental health. This ranges from family systems to idioms of stress, from beliefs in deities to religious ceremonies and exorcism rituals. A revision of current thinking must challenge the cultural

arrogance and racist ideology deeply entrenched in many mental health/illness assumptions of the West.

Strategies for changing attitudes and practices must be aimed at all levels - international, national and personal levels. Anti-racist strategies need to be implemented and tailored towards each cultural situation. At the international level, WHO must eliminate racial bias at all levels by re-examining its research projects, careful selection of 'experts' without prejudice and its mode of service of delivery. At the national level, it is imperative that regular checks be made as to whether the various States and Territories have made significant progress in innovation and service delivery as directed under the National Mental Health Strategy. At the local level, cultural competence training for staff should be regarded as mandatory. Within this training, staff should be encouraged to examine their own biases and prejudices. In addition, the training should include an examination of the value and benefits of alternative treatments, and an awareness and acceptance of other cultural practices and beliefs. All training should be aimed towards a shift in current thinking so that all cultural traditions and practices are accepted as equally valuable and beneficial. Although undoubtedly, there will always be some common and universally accepted practices, any explanatory models should be client-focussed and dictated by the culture from which the client originates.

It is hoped that this research will be treated as a positive contribution to knowledge in the area of mental health. By addressing racism within the mental health system and acknowledging the valuable contribution of all cultural practices and traditions, it is hoped that there will be diversity within unity by upholding a culturally relativistic view which is integrated into a universalist approach.

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