

Re-Conceptualizing “Trauma”: Examining the Mental Health Impact of Discrimination, Torture & Migration for Racialized Groups in Toronto

Summary report by **Kwame McKenzie**

Principle Investigator

Ingrid R.G. Waldron, Ph.D.

Assistant Professor, School of Occupational Therapy
Dalhousie University, Halifax, Nova Scotia

Research Assistants

Sasha Henry-James,

MA student, Department of Social Work, York University

Adetilewa Akin-Aina,

BA, Double Major, Biology and Psychology, University of Toronto, Mississauga

Acknowledgments

The research team would like to thank the following individuals for assisting with this research project:

Focus Group Members

Mental Health Professionals

Research Advisory Committee

Dr. Ted Lo, Center for Addiction and Mental Health

Dr. Kwame McKenzie, Center for Addiction and Mental Health

Aseefa Sarang, Co-director, Across Boundaries

Martha Ocampo, Co-director, Across Boundaries

Executive Summary

Understanding the social determinants of health is important in therapeutic encounters with clients. Ethno-racial service providers are preferred by some communities not just because they understand their culture but because they understand their current social realities. However, with the pressure of service these understandings are rarely documented.

Ingrid Waldron has undertaken a study for Across Boundaries investigating the social realities of the clients they serve. Specifically the work looks at the impact of life events, stress and discrimination on mental health. It focuses on the experiences of four main groups:

- 1) asylum-seekers;
- 2) refugees;
- 3) recent or long-term immigrants; and ,
- 4) Canadian-born racialized individuals.

The main clinical aim of the study was to identify how mental health professionals can more effectively respond to the complex experiences of racialized groups in Canada.

The methods were a literature review and focus groups with professionals who work with people from ethno-racial groups who have mental health problems and clients

The results are compelling and complex. They attest to the central importance of racism in the daily lives of clients dealing with racism in the daily experience of health providers. They describe the interplay between past trauma and the everyday trauma that is the experience of discrimination at a psychological, physical and emotional level.

The main results:

- There is emotional, psychological, spiritual and physical distress that asylum seekers, refugees, immigrants and Canadian-born racialized groups continue to suffer in Canada due to social exclusion, social inequality and discrimination. These are important to their mental health.
- The impact of discrimination and how it interacts with other social determinants means that it is experienced as trauma and could be usefully considered as such by mental health professionals.
- Some of the major barriers that prevent individuals from coping with discrimination and the migration experience include: a) lack of support systems; b) misplaced family members due to war; c) family conflict and breakdown; d) peer pressure from other disenfranchised youth; and e) systemic and structural discrimination
- It is important to acknowledge the mental health impact of multiple oppressions for clients who are dealing with both racism and heterosexism from their partners, their families and the wider community
- The mental health problems that migrants and victims of torture suffer may be linked to their failure to secure legal status in Canada and the ongoing limbo in which they find themselves

- Some diverse peoples downplay feelings of sadness and hopelessness. These feelings may present as physical symptoms, such as headaches, stomach problems and muscle pain.
- Culturally diverse clients may use a variety of approaches to cope with mental health problems, including religion and spirituality, support from friends, family and community, as well as herbal medicine, yoga, home remedies, acupuncture and various forms of complementary medicine
- Racialized and LGBT clients may be “harmed” by mainstream mental health services because they operate out of heterosexist norms and values and have little understanding of how race and issues relating to racism should be incorporated into programs and service delivery.

Racialized Groups- *is the term used by Ontario Human Rights Commission and other organizations which recognizes the dynamic and complex process by which racial categories are socially produced by dominant groups in ways that entrench social inequalities and marginalization. Stats Canada uses the term “visible minorities” which is more static and relates primarily to number and colour.*

The key recommendations:

Mental health providers who deal with racialized groups should understand the impact of racism on health.

Staff must be culturally competent, i.e. they need to have an understanding of how multiple oppressions operate in the lives of racialized peoples; how to work with internalized oppression; how to conceptualize discrimination as a form of trauma; and how to acknowledge the existence and reality of racism.

Education and training of health and settlement agencies on cultural competency and anti-racism/anti-oppression must be well integrated in all aspects of the organization

Psychological treatments as well as instrumental help and support in dealing with discrimination rather than treating its impacts with medication should be a primary focus of services

Settlement agencies need to acknowledge health and mental health issues as central to service delivery and policy.

There needs to be more links between the services provided by settlement workers, social workers, physicians, psychiatrists and other services in providing care for patients. These links will also allow these professionals to be better able to support one another in the work that they do.

I. Literature review

Victims of torture have been the focus of much research in the past few decades. The increasing attention to the mental and psychological impact of torture on victims has resulted in a growing body of research on “trauma” and (PTSD). There is, however, a group of scholars that have long questioned the usefulness of the term “trauma” for explaining responses to torture and other traumatic and distressing events. (Ommeren, Saxena & Saraceno, 2005 and Summerfield, 1999) They also question the authenticity and existence of PTSD, perceiving it as a socially constructed disorder that lacks scientific validity, the propensity to medicalize trauma and the effectiveness of interventions designed to reduce traumatic stress.

Summerfield (1999) notes that the medicalization of distress in the psychiatric community demonstrates a tendency to apply biological and scientific constructs to responses by victims that makes sense within their socio-cultural environments. This suggests that it may be more useful for mental health professionals to incorporate “indigenous” knowledges and culturally-specific vocabularies of distress into assessment and treatment plans in non-Western conflict and post-conflict areas.

This research report examines trauma as it relates to experiences of psychological and physical torture, it also seeks to acknowledge the full breadth of the “trauma” experience to include the emotionally and psychologically destabilizing experience of migration, settlement and discrimination for migrants and Canadian-born racialized groups in Canada.

The decision to enclose the term “trauma” in quotation marks is a way to denote both the need to interrogate its validity as a psychiatric illness and the need for the term to be re-conceptualized in ways that acknowledge continuing forms of “trauma” experienced by racialized groups in Canada. Although the psychiatric impact of “trauma” and torture has received a great amount of attention in the literature over the past few years, fewer studies consider how experiences of persecution, torture, confinement in refugee camps and family dislocation can result in what Sweet (2007) calls a super-heightened sensitivity to discrimination and injustice, resulting in the “re-traumatization” of migrant groups. While it is important to appreciate the psychological impact of state violence for migrants, it may be even more important to extend the “trauma” discourse in ways that more fully acknowledge how social exclusion, social and economic inequality and discrimination based on race, gender, sexual orientation, culture, religion and other social constructs in Canada may produce or exacerbate mental health problems among asylum seekers, refugees, immigrants and Canadian-born racialized groups.

There is a growing body of research that seeks to conceptualize discrimination, and particularly racism, as “violent” and “abusive”. For example, Fanon (1963) argues that the abuse that oppression inflicts on oppressed peoples results in a profound sensitivity, the erosion of self-respect and self-worth, and, consequently, mental pathology.

Similarly, Fernando (1998) argues that racism represents a psychological assault on the sense of self and that the devaluation and demoralization that Black people experience as a result of racism often leaves them spiritually destitute, disconnected, and alienated. Waldron (2002) uses the concept “colonial pathologies” to refer to those mental health problems that are produced from living in oppressive societies and that are not necessarily rooted in some biological, chemical or genetic malfunctioning. Bryant-Davis and Ocampo (2005) liken racist incidents and their mental and psychological impact to the trauma experienced by victims of rape and domestic abuse, arguing that all three events (racism, rape, domestic abuse) produce cognitive problems, such as memory problems, problems concentrating, and self-blame (Morris-Prather, Harrell, Collins, Jeffries-Leonard, Boss & Lee, 1996), emotional difficulties, including problems trusting individuals who are similar to their perpetrators (Rutter, 1993) and physiological problems, such as somatic complaints (Clark, Anderson, Clark & Williams, 1999).

Other scholars conceptualize racism in more subtly violent ways by arguing that it imposes an alien worldview upon its victims. For example, Wright (1974) coined the term “mentacide” to refer to the “silent rape” of a people’s collective mind by the perpetration, penetration and perpetuation of alien culture, values, belief systems, or ideas for the purpose of group destruction. He argued that mentacide occurs when subordinate groups such as African Americans accept and internalize the culture, values, and belief systems of the dominant group, resulting in the destruction of African self-consciousness and the adoption of the behavioural characteristics of the oppressor. Baldwin (1980, p. 100) expounded on this notion of “racism as violence” by arguing that Europeans are able to gain psychological control over non-European peoples by imposing a Eurocentric world view upon them. Nobles (1976) called this “conceptual incarceration” of Black people and states that:

The natural consciousness of Black people is forced to relate to a reality defined by White consciousness. That is, contemporary Black people in the United States live in a psycho-social reality consistent with and supportive of white mental functioning. Such a situation is tantamount to Black people living in what for Black people must be White insanity (p. 26).

Similarly, this research seeks to widen and re-conceptualize the conventional and Euro-Western “trauma discourse” to acknowledge the full breadth and complexity of the “trauma” experience for racialized groups by examining the intersecting dynamics of two main issues: a) state violence and b) the violence of discrimination in Canada. It asks three main questions: 1) How can conventional and Euro-Western understandings of “trauma” in the literature and in psychiatry be extended in ways that acknowledge the ongoing emotional, psychological, spiritual and physical distress that asylum seekers, refugees, immigrants and Canadian-born racialized groups suffer from in Canada due to social exclusion, social inequality and discrimination?; 2) To what extent does the “medicalization of distress” (i.e. the propensity to apply scientific labels to coping

responses) in psychiatry undermine or dismiss the role that “socio-cultural context” plays in producing and exacerbating mental health problems for individuals coping with the emotional, psychological, spiritual and physical ramifications of torture, migration, settlement and discrimination?; and 3) How can mental health professionals challenge the pathologizing tendencies of psychiatry and the mental health system to more effectively respond to the mental health belief systems and coping styles of asylum seekers, refugees, immigrants and Canadian-born racialized groups?

This research utilizes a critical integrative framework that recognizes that individuals live their lives as complicated beings that belong simultaneously to one or more social categories. A critical integrative analysis can be particularly useful for grappling with and complicating the issue of diversity in Canada because it articulates how ethnicity, race, culture, gender, sexual orientation, religion/ faith, and other social identities intersect simultaneously in the lives of community members and are implicated in their experiences accessing services and programs. It also demonstrates how various structures and processes within societies stratified by socially constructed markers of difference (race, gender, and class etc.) impact on social relations and human interaction and how individuals and groups are positioned differently within hierarchies of power. Moreover, a critical integrative analysis seeks to reveal the processes through which inequalities are produced and reproduced within institutional structures, and questions the power, privilege, and dominance that result from unequal relations.

Racism and social determinants of health

This study extends conventional notions of “trauma” in ways that consider how discrimination based on race, gender, sexual orientation, religion and other social constructs represent a psychological assault on the sense of self for racialized groups in Canada. A “social determinants of health” approach is useful for pinpointing the social, environmental, economic, and political factors that compromise the health status and well being of marginalized groups, communities and jurisdictions. Raphael (2007) identifies these social determinants as health status and health services; early life; education; employment and working conditions; food security; income and income distribution; social exclusion; social safety net; unemployment; employment insecurity; and poor housing. Moreover, a critical analysis of mental health must also consider other social factors that impact on mental health, including race, immigration and refugee status, age, gender, sexual orientation, and social class. A report by Access Alliance Multicultural Community Health Centre (2007) also identifies the following social determinants as compromising health and well-being: lack of access to services and transportation; lack of formal or informal child care; exposure to violence; criminalization and racial profiling; educational streaming; racial/cultural stereotyping; unequal access to information; and concentration in racially segregated neighbourhoods. Both the report by Access Alliance and Wilkins, Berthelot & Ng (2002) conclude that these social determinants are associated with a host of health and mental

health problems, including accidents, anxiety, alcoholism, drug dependency, depression, suicide and homicides.

In considering mental health specifically, it is important that it be conceptualized in a holistic way - one that acknowledges the mental, physical, emotional, psychological and spiritual health and well-being of individuals. For the mental health of immigrants and refugees specifically, three main migratory experiences impact on mental health: 1) pre-migration experiences, including experiences of war, religious persecution, physical and psychological torture and abuse, as well as other forms of trauma; 2) settlement experiences, including the various events and barriers that immigrants and refugees encounter in attempting to settle into the host country, including culture shock, psychological distress, language barriers, difficulties accessing institutions (employment, education, health) and discrimination and racism; and 3) post-migration experiences, including that period of 6-10 years after migration when there is an expectation that immigrants and refugees have successfully integrated into the host country, which is often not the case.

Emerging studies (Ali, McDermott & Gravel, 2004; Halli & Anchan, 2005; Hyman, 2003; Women's Health Surveillance Report, 2004; Wu & Schimmele, 2005) show that the health advantage that recently arrived immigrants and refugee groups enjoy over longer-term residents and Canadian-born populations gradually erodes over successive generations. This "healthy immigrant" effect" highlights the role that various social determinants (social inequality, unemployment, the migrant experience, poverty, marginalization and discrimination) play in putting immigrants and refugee groups at risk for developing chronic diseases and other health problems over several generations. For example, the results of the 2000-2001 Canadian Community Health Survey, which were reported in the Women's Health Surveillance Report (2004), indicates that recently arrived immigrant women were less likely to report poor health than Canadian-born women within the first two years of their arrival, but more likely to report poor health after having been in Canada for at least 10 years.

Other studies (Gee, Kobayashi & Prus, 2004; Halli & Anchan, 2005; & Haws, 2005) suggest that a number of factors converge to predict health status for immigrants, including age and length of residence in Canada, self-selection in the immigration process, the socio-economic advantage (educational and occupational opportunities) of new immigrants and the health requirements of the immigration policy that admits only the healthiest immigrants to Canada. This makes sense since the individuals that are most likely to self-select in the immigration process are younger, better-educated and healthier immigrants. Wu & Schimmele (2005) question the health advantage of new immigrants given that the migration experience may put these individuals at increased risk for depression and other mood disorders. They found that age at the time of arrival in Canada plays a significant role in mental health status for immigrants, with younger immigrants (arrived in Canada before age 18) experiencing worse mental health than all other immigrants due to the many difficulties they face fitting into a new social environment, as well as the pressures arising out of conflicts between values in their home environment and those in the school environment. In addition, since long-term immigrants who have lived in Canada for more than 10 years tend to be older than the

average member of the Canadian-born population, it is not surprising that their health status will be poorer. Moreover, while recent mid-life immigrants (45-64 years) who immigrated to Canada less than 10 years ago report better health than immigrants who arrived 10 or more years ago and Canadian-born individuals, recently arrived immigrants who are 65 years and over report poorer health compared to longer-term residents and Canadian-born individuals. Haws (2005) also identified other factors that put immigrants at an increased risk for chronic disease and other health problems including weight gain, declining rates of physical activity and alcohol and cigarette use.

Ali, McDermott & Gravel (2004) found that the rates of depression for immigrants who arrived 10-14 years ago and those who arrived 20-29 years ago were similar to the Canadian-born population. Long-term residents who had been in Canada for over 30 years have similar rates of alcohol dependence as the Canadian-born population. In addition, this study found that region of origin was significant, with immigrants from Asia having the lowest rates of depression and immigrants from Europe and North America experiencing rates similar to the Canadian-born population.

Discrimination, particularly racism, is one of the most if not *the* most significant social determinant impacting on the health and mental health of racialized groups in Canada. In one of the first studies on race and mental health in Canada, the Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988, p. 12) describe the impact of discrimination in Canada on mental health:

“The basis for much of the mental health problems in Canada is moderate systemic racism throughout our society...The racism that lingers is still powerful enough to place visible minority people under the pressure of always being on watch for the hard edge of prejudice and discrimination. It is the individual representations of this racist plague that underlies, we think, many of the psychosocial problems immigrants and refugees manifest”.

Theories on stress offer a useful framework for understanding discrimination and racism as stressors that elicit emotional, psychological and physical responses that are similar to general experiences of stress. Lazarus and Folkman (1984) argue that it is an individual's appraisal of the seriousness of an event, as well as her coping response that will determine whether she will respond with psychological stress. Their theory on stress focuses on three main factors: the person-environment interaction; primary appraisal; and secondary appraisal. The person-environment interaction describes how an individual cognitively assesses the impact of the environment on her well-being. Primary appraisal is the process of determining a stressor's potential threat, anticipated harm, or the harm/loss that has already occurred. Secondary appraisal is the phase in which an individual determines whether the kinds of coping resources she has is adequately effective in coping with the impending environmental stressor. Meyer (2003) identifies two main approaches for understanding stress. The first approach perceives stress as an objective and observable phenomenon that is experienced as stressful by

individuals who are forced to adapt, manage, and cope with it. The second approach characterizes stress a subjective phenomenon that is created by the relationship between the individual and her environment – a relationship that is influenced by the external event and how the individual appraises that event.

Other researchers draw from these and other theories on stress by making direct associations between racism and stress. For example, Abbott (1995) identifies three main reactions to stress as physiological, emotional, and cognitive. When stress is associated with racial discrimination, the physiological reactions may include changes in eating patterns, sleep, and blood pressure and increased use of alcohol and other substances. Emotional responses include depression, anxiety, paranoia, anger, hopelessness, helplessness, despair, and social isolation. Finally, cognitive reactions involve attempts to explain or interpret the cause of the experience, what it means for the individual in terms of self-esteem, and how she will interact with others and cope in the future. Outlaw (1993) uses models of stress and coping as frameworks for understanding the psychological and somatic consequences of African Americans' daily encounters with racism and oppression. She stated that when African Americans encounter racism, they make an appraisal of the situation as harm/loss, threat or challenge. Following this appraisal, they take an inventory of their available coping resources prior to responding to the situation. Finally, Landrine & Klonoff (1996) also conceptualize racist events as culturally specific stressors and use theoretical models and checklists from generic stress research (e.g. Hassles Frequency Scale; Perceived Stress Scale) to analyze the mental health impact of racist events.

It is also important to understand the impact of both the macro and micro aspects of discrimination and racism on the psychological and mental health of racialized groups. When looking at the broader societal structures, it is important to acknowledge the health and mental health impact of racism as a product of structural racism that operates through the laws, norms and rules of governance at the societal level, institutional racism that is embedded in the processes and practices of organizational structures and “everyday discrimination” that is expressed in interpersonal relations and daily interactions between individuals. Taken together, these experiences put racialized groups at risk for stress, impaired psychological functioning and chronic disease. Studies in Canada, the US and Britain provide strong evidence for a correlation between discrimination and negative health effects. Noh, Kaspar & Wickrama (2007) argue that both overt and subtle discrimination in Canada impact mental health through different intra-individual processes. They found that overt discrimination resulted in an erosion of positive affect, independent of emotional or cognitive mediators and that subtle bias resulted in more complex emotional and cognitive appraisal of experiences that produce distress.

The Fourth National Survey of Ethnic Minorities (Karlsen & Nazroo, 2002) found that discrimination had negative health consequences for Indian, Pakistani, Chinese, and Caribbean groups in Britain. Respondents who were victims of racially motivated physical attacks and vandalism were 100% more likely to report fair or poor health than respondents who were not victims of such attacks. Respondents who were victims of racist verbal abuse were 50% more likely than those who were not victims to describe

their health as fair or poor. Finally, respondents who experienced verbal abuse had an 85% increased risk of developing respiratory illness and a 150% increased risk of developing psychosis and depression than those who were not victims of verbal abuse. The National Survey also found that Caribbean, African, and Asian respondents who had been victims of racial verbal abuse were three times more likely to suffer from depression or psychosis. They were also nearly three times more likely to suffer from depression and five times more likely to suffer from psychosis after experiencing a racist attack. Following this study by Karlsen and Nazroo, Karlsen, Nazroo, McKenzie, Bhui, & Weich (2005) determined the relationship between racism and common mental disorders (CMD) and psychosis for Caribbean, Indian, Bangladeshi, Pakistani and Irish people in England. The study was particularly interested in investigating how this relationship is shaped by race, ethnicity, gender, age and socio-economic status. The findings demonstrate that there was an increased risk of CMD and psychosis due to racially motivated verbal abuse or physical assault in the combined gender and ethnic minority group multivariate models and that the experience of overt, everyday discrimination (verbal abuse, physical assault) and institutional and systemic discrimination (workplace discrimination, perception of racism in British society) are independently associated with CMD and psychosis.

Other studies (Bhugra, Leff, Mallett, Der, & Corridan, 1997; Os van, Castle, Takei, Der, & Murray, 1996) show that African Caribbean people in Britain have higher rates of psychotic illness than the indigenous White British group. Interestingly, several studies (Bhugra et al., 1997; Hickling & Rodgers-Johnson, 1995) indicate that rates for psychotic illness are not similarly raised in the Caribbean. There is a consensus (McKenzie, Hutchinson, Fearon (2008) that second generation African Caribbeans (born in the UK) experience higher rates of psychosis than their Caribbean-born counterparts, suggesting that mental health is negatively impacted by adverse environmental factors, such as racism and discrimination in housing, employment, social and health care and the legal system.

For racialized women, health status is a product of their exposure to multiple and interlocking oppressions, including race, gender, class and poverty. An understanding of health and illness for racialized women, specifically, must consider how the multiple consciousness of these women is a product of their history as a racialized group (slavery, genocide, relocation), the secondary status of these women due to hierarchies of race, gender and class and systemic inequalities that arise out of those hierarchies (discrimination in employment, housing and society; unequal protection under the law) and their complex relationship to their own communities that simultaneously buffers them from the hard edge of discrimination and subjects them to lingering internal problems due to a legacy of oppression that is typical within racialized communities. Thomas Barnard (2003) found that for Black Nova Scotian women, the cumulative effect of systemic racism in their lives puts them at an increased risk for a host of chronic diseases and other health and mental health problems, including depression and suicide; fear, mistrust, despair, alienation, and loss of control; damaged self-esteem; drug and alcohol abuse; violence; high stress and stress related diseases; short lifespan; poor pediatric care, infant; hypertension; cardiovascular disease; high blood

pressure; stroke; psychological stress; diabetes; breast cancer; and lupus. Schulz, Israel, Williams, Parker, Becker, & James (2000) examine the cumulative effects of multiple stressors on women's health, by race and area of residence. More specifically, they examined the cumulative effects of socioeconomic status, experiences of unfair treatment and acute life events by race and residential location on the health status of African American and White women living within the city of Detroit and in the surrounding metropolitan area. They found that African American women (regardless of whether they live inside or outside the city) report more frequent experiences with everyday unfair treatment than White women. They also found that African American women residing in the city reported a greater number of acute life events than White women residing outside the city. African Americans are also more likely to experience stressful conditions and are more negatively affected by these stressors than higher status groups. Schulz et al. conclude that, overall, African American women reported less favourable general health status than did White women.

The studies cited here suggest that racism and discrimination have a profound impact on the daily lives and mental health of racialized groups. Its cognitive, emotional and physiological impacts though less acute are linked to increased rates of serious diseases on a population level. The experience of racism at an individual level is traumatic and on a population level it is difficult not to conclude that racism should be considered as a form of violence.

Conceptualizing Illness

Models of illness, symptom presentation and treatment are closely linked. The preference that a particular cultural, racial or ethnic community has for treating mental illness will be determined by that community's perception of how mental illness originates and is explained, as well as how that community presents symptoms of mental illness. The term "indigenous" is used here to characterize what is often referred to as ethno-medicine or "folk" medicine practiced by peoples in Western and non-Western societies and which is thought to differ in significant ways from Western medicine or biomedicine.

Perhaps what most distinguishes Western medicine and psychiatry from the indigenous/ traditional healing systems of non-Europeans is its tendency to separate the material from the non-material in explaining illness causation and in treating illness. The material includes those tangible explanations that can be seen concretely, whereas the non-material includes those psychic, spiritual, and mystical explanations that may not be visible in a concrete way. Whether we use the term "mind-body", "mind-body, spirit", or the more inclusive "mind, body, spirit, and emotions", we are describing the truly whole and integrated person. While Western medicine has separated mind and body and largely ignored the importance of spiritual health until recently, Eastern, African and Aboriginal healers have long recognized the interconnectedness of the parts that make up the whole. Unlike Western medicine, where a dichotomy of physical and "mental illness" is articulated, a majority of non-Western "mental illness" is explained in

personalistic (emotional) rather than naturalistic (physical) terms: (a) possession of the patient's body by a ghost, spirit, or deity; (b) punishment for breaking a taboo; or (c) witchcraft (Foster & Anderson, 1978). Torrey (1986) states that metaphysical causes such as the loss of the soul, the intrusion of a spirit into the body, sorcery, and the angering of a deity are prevalent in much of the world. Moreover, while many Europeans have a tendency to express their beliefs through animistic concepts and objects, many African peoples of the diaspora express theirs through superstition, magic, and spirituality. Mind-body medicine is based at least in part on the idea that to heal a physical illness, one must first address the underlying emotional or spiritual cause. Indeed, many traditional healers believe that illness or disease begins in our minds with an emotion and manifests itself in the body as symptoms.

Fernando (1991) argued that the divide between the material and the non-material or the mind and body has been sustained in Euro-Western psychiatry. In the following quote, Fernando (1992) characterizes "mental illness" as a socially constructed concept:

Psychiatry depends on identifying illness, but it has neither an objective means of measuring, nor a precise culture-free classification of illness. At best, psychiatry is a body of knowledge about people built on a framework of hypotheses and information. . . these norms -- the values, ideologies, and assumptions that have fashioned psychiatry and continue to permeate it -- come from the culture within which psychiatry lives and grows. This has been, and still is, broadly Western culture -- or perhaps West European culture. So psychiatry, by its very nature, is ethnocentric to European culture (i.e. Eurocentric). The fact that it has been applied -- or rather imposed -- all over the world says something about power and status rather than about usefulness or validity" (p. 10)

When psychiatry is imposed globally in this way, it has the effect of suppressing indigenous methods for dealing with social, emotional, and mental health problems. It also has the effect of influencing almost every aspect of mental health services in non-Western countries, from the Western-trained medical staff to the models and systems that have been devised in the politically powerful Western centres of "excellence". The result is that indigenous systems of psychology, philosophy, and medical care in these countries are stifled in the name of modernity, development, and uniformity and are devalued in favour of Western models that are perceived to be superior (Fernando, 1991). McClintock (1995, p. 16) argues that imperial power emerged from a culmination of historical processes that were constituted haphazardly from a myriad of encounters with alternative forms of authority, knowledge, and power. She points out that four main factors interact in ways that allow psychiatry to operate as an imperial force around the world: a) the belief in the superiority of Western culture; b) the medicalization of psychiatry, i.e. its status as a valid appendage to Western medicine; c) assumptions that psychiatry is based on objective truths and is therefore scientific; and d) racism, i.e. the utilization of racial stereotypes to assess, diagnose, treat, and control racialized peoples.

Since psychiatry is inspired and rooted in the common-sense of the society in which it operates, it is important to interrogate its reliance on the common-sense of European thinking and values to assess racially and culturally diverse peoples among some psychiatrists and individuals working within the health and mental health fields. It is also important to understand how the operationalization of psychiatric knowledge within mental health institutions can inhibit racially and culturally diverse groups from accessing psychiatric institutions and mental health services.

Coping with mental health problems and finding help

Foucault's work provides a good basis from which to understand how power is embedded within medical and psychiatric institutions and within the relationship between patients and physicians. In *Discipline and Punish* (1979), Foucault suggests that power in feudal societies tended to be unstable and decentralized, whereas in modern societies power is embodied in the practices of surveillance, correction, and coercion that operate within agencies of punishment (prison, psychiatric institutions). He argues (p. 192) that the "patients" or "cases" that are created within these institutions through this process of "examination" are subjected to power that is exercised through the application and imposition of particular forms of knowledge that are legitimized within institutions. In *Birth of the Clinic* (1975), Foucault examines how "technologies of power were legitimized and authorized within psychiatric institutions through "scientific" discourse. He argues that power is operationalized when institutions use scientific knowledge to impose labels that characterize individuals as "insane", "hysterical", or "frigid". The knowledge that pervades psychiatric institutions, in particular, is imposed within the context of various dichotomies (mad/sane; dangerous/harmless; normal/abnormal) which, in turn, produce labels and diagnoses into which each individual must fit. These labels and diagnoses are used to determine the nature and personality of the individual, how she/he is to be labelled, her/his location and place in society, and how she/he is to be disciplined. In *Madness and Civilization* (1965), Foucault characterizes the relationship between the patient and the therapist in psychiatric institutions as one of both intimacy and control. He also suggests that the fields of medicine, psychiatry, and criminology all exercise power on individuals through a process of labelling and categorization.

According to Fenta, Hyman and Noh (2007), there are inconsistencies in the research on the extent to which immigrants utilize healthcare services, with several studies showing that immigrants under-utilize health services compared to Canadian-born residents and other studies indicating that they use these services more than the Canadian-born population. Various explanations have been offered for the underutilization of health services by immigrants, such as language barriers, cultural distance between health providers and clients, unfamiliarity with the health system and racism. Fenta, Hyman and Noh found that 85% of study participants used at least one type of health service and that a family physician was most frequently used. Few of these participants (12.5%) attended formal health services for mental disorders, but

when they did, they were most likely to see their family physicians. The study also found that females were more likely than males to seek out health services from “mainstream” healthcare providers, particularly family physicians and hospital inpatient services. McKenzie and Bhui (2007) provide strong evidence for differential treatment based on race and ethnicity in the health care system in Britain, showing that race and ethnicity have bearing on the type of treatment that is offered to clients. The study suggests that, regardless of socio-economic status and diagnostic differences, psychotherapy is less likely to be offered to Black and ethnic minority groups and that more controlling treatment approaches are used for Black and ethnic minority groups, including drugs and various other forms of coercion.

It is not surprising, then, that many culturally and racially diverse groups are often hesitant to receive treatment from Western-trained psychiatrists. Studies conducted by Across Boundaries (1997) and Bojuwoye (2005) suggest that many of these individuals don’t access health services because they utilize Euro-Western assessment and diagnostic categories that are not culturally applicable within non-White communities. Consequently, many immigrants and refugees encounter difficulties or barriers accessing health care services and mental health institutions. Some of these barriers include 1) lack of health insurance coverage; 2) language and communication barriers; 3) lack of information on health services and finding a doctor; 3) cultural misunderstandings; 4) ideological conflicts between their health beliefs (which are often spiritually grounded and holistic) and those of the Canadian mental health system (which is predicated on a Euro-Western and scientific conception of illness and health; and 5) culturally insensitive and incompetent health care professionals.

It is important to note, however, that an increasing number of individuals in North America are using complementary medicine, which integrates aspects of “indigenous” or “folk” medicine with aspects of Western medicine. A study conducted by Berthold, Megan, Wong, Schell, Marshall, Elliott, Takeuchi and Hambarsoomians (2007) found that more than a third of adults in the US use some form of complementary and alternative medicine found outside the confines of the conventional, Euro-Western health system. The study also suggests that Asian Americans, particularly Asian American immigrants, may be more likely to use complementary medicine for mental health problems if they perceive mental illness as originating from underlying physical problems, metaphysical imbalances or offenses committed against spirits or deities.

Waldron (2003) found that many African Canadian women often heal their mental health problems by combining Western psychiatric approaches with the more traditional practices that are indigenous to their cultures. This includes one or more of any combination of psychiatry, psychoanalysis, a family doctor, meditation, yoga, herbal remedies, solitude, diet regulation, relaxation, social support networks, divination, spirituality and prayers. These women’s choice of treatment is determined by their personal beliefs about how “mental illness” is manifested. If they are struggling with relationship problems, their response is typically medical and they will go to a family doctor or psychiatrist. If they believe the cause to be spiritual, however, they may go to an indigenous healer or engage in prayer or meditation.

Re-Conceptualizing “Trauma”

A significant problem with mainstream psychiatry is that issues are often not appropriately contextualized and/or placed within their social, political, or historical contexts. It is difficult to understand and treat non-Western and racialized peoples without an appreciation for how their individual and collective identities are shaped by these social, political, and historical forces. Positivist approaches, such as those often used in medicine and psychiatry, are typically concerned with using objective generalizations to define reality through a scientific lens. Western science has long been concerned with issues of power and authority and the investigation of issues that are external to the individual being studied. Mahoney (1996) argues that the assumption of Western White male epistemologies, in particular objectivism, is that the only valid truth is one that is based on rational order and reason. It is an approach that perceives truth and reality to be singular, stable, and external to the subject under study and negates the significance of plurality, perspective, diversity, and change within the research field.

The research outlined here will attempt to re-envision “trauma” by investigating the links and interactions between the emotional, psychological, spiritual and physical impact of state violence and the violence of structural, institutional and “everyday” discrimination for racialized groups in Canada. State violence and racism are considered types of trauma that have predictable impacts. However, rather than pathologise these sorts of social suffering as is usual in clinical practice the aim is to investigate whether there are alternatives to the medicalisation of trauma and whether refocusing the lens used by clinicians can help them to better respond to the complex experiences of racialized groups in Canada.

II. Research Objectives

This research study three main objectives:

- To investigate the links between the emotional, psychological, spiritual and physical impact of state violence and the violence of structural, institutional and “everyday” discrimination for racialized groups in Canada;
- To consider the ways in which the “vocabulary of distress” in psychiatry is associated with biological and scientific ideologies about illness causation, the “medicalization of distress” and trauma in the clinical literature and mental health practice and the socio-cultural context in producing mental health problems; and
- To identify ways in which mental health professionals can challenge the pathologizing tendencies of psychiatry and the mental health system to more effectively respond to the complex experiences of racialized groups in Canada.

III. Methodology

This research utilizes a critical anti-oppression framework that is concerned with the complexities of the human experience, rather than a so-called “truth”. It recognizes that knowledge is constituted socially and historically. The research sought to be empowering for participants by actively involving them in the construction and validation of knowledge and enabling them to read domination from their own standpoints. The researcher also sought to address the power imbalances that exist in the wider society and within the research environment by fostering an equitable relationship with participants that was dialectal, reciprocal, interactive, collaborative, reflexive and mutually educative.

The research utilized two main qualitative approaches to data collection: individual interviews and focus groups. Qualitative research approaches are multi-method in focus, involving the studied use of a variety of empirical data. They allow for a complex articulation of the intricacies of the human experience because they validate knowledge that emerges from subjective, personal, emotional, experiential, and intuitive frames of reference. More than any other research approach, interviews and focus groups are dialectal because they provide participants with a forum to express their thoughts, emotions, experiences, and knowledge in a collaborative and reciprocal environment. They rely on a transformative approach to knowledge-building that is change-enhancing, interactive and socially, culturally and historically contextualized. Finally, qualitative approaches can be effective in obtaining detailed information on sensitive and emotional issues because they allow the interviewer/ researcher to probe and explore participants’ experiences in complex ways.

Recruitment & Sample: A total of 46 participants took part in this research. The sample was recruited between February and March of 2008 and includes 32 clients of mental health and community-based agencies in Toronto, seven service providers at Across Boundaries and seven mental health professionals and service providers employed in hospitals and community-based agencies. Two main methods were used to identify and recruit the research sample:

- 1) Service providers at two community-based agencies identified and invited interested clients to participate in the focus groups and
- 2) The researcher in collaboration with Martha Ocampo at Across Boundaries invited service providers and mental health professional to participate in individual interviews.

Four focus groups comprising of racialized clients of community-based agencies were conducted. The focus groups comprised of participants that were diverse based on race, culture, religion, and immigrant and refugee status. The following focus groups were conducted:

- A focus group comprising of 10 female participants, including six Muslim Afghani and four Muslim Somali women;
- A focus group comprising of six female participants, including two from the Republic of Congo, one from Ethiopia and three from Sri Lanka;
- A focus group comprising of eight Tamil participants, including seven females and one male; and
- A focus group comprising of eight racialized male and female participants, including two women who were born in Jamaica but have resided in Canada for most of their lives and six men from diverse cultural backgrounds, including one male participant who was born in England of Jamaican heritage and has resided in Canada for most of his life; one male who was born in Jamaica and has resided in Canada for most of his life, two men from Eritrea, one man from Ethiopia and one man from Guyana.

In addition, one focus group comprising of seven racially and culturally diverse service providers from Across Boundaries was conducted, including one Case Manager for Mental Health and Justice; three Adult Mental Health Workers; one Crisis Worker; one Intake Worker; and one Program Coordinator. Finally, individual interviews were arranged with seven service providers and mental health professionals with particular expertise in treating people from racialized groups..

Data Collection: The following two data collection tools and methods were used: a) a semi-structured focus group questionnaire (please see Appendix A) and b) a semi-structured interview guide (please see Appendix B). Each interview lasted approximately one hour and each focus group lasted approximately two hours. Both tools consisted of a set of questions that were carefully worded and arranged with the intention of taking each participant through the same sequence. Although the tools were constructed with a clearly defined purpose, they allowed for some flexibility in wording and in the presentation of questions. In other words, they were sufficiently flexible to allow the researcher the freedom to modify the wording or order of questions so that the interview and focus group processes captured the issues that participants wished to focus on and gave a sense that the interviews and focus groups were being driven by both the researcher and the participants.

Data Analysis: The research data was analyzed using a basic thematic categorization process that is outlined in the book *Theoretical Sensitivity* (Glaser, 1978). This thematic categorization analytical process involves identifying, organizing, categorizing and interpreting relevant themes relating to the research questions (outlined earlier in this report) and research themes arising out of focus group and interview questionnaires. A theme can be defined as a statement of meaning that runs through all or most of the pertinent data or is one in the minority that carries heavy emotional or factual impact. It is important to recognize, however, that thematic categories arising from the data often arise out of the questions in the research tools. The questions presented in data collection tools will always have some influence on the kind of themes and issues that

will be elicited by participants during interviews, focus groups and public meetings, which will, in turn, determine the kinds of thematic categories that arise from the data during analysis.

Inductive analysis was used to assess the extent to which the various themes and categories in the data described patterns and phenomena that participants had conceptualized and defined during the course of the interviews and focus groups. In inductive analysis the patterns, themes, and categories of analysis emerge out of the data rather than being imposed upon them prior to data collection and analysis. The objective was to bring order to the data by organizing what was there into patterns, categories, and basic descriptive units. This process is described in more detail below:

- Handwritten data from focus groups and interviews were typed and transferred into a first draft document of the research report;
- Data in the draft report were reviewed in order to obtain commonsense impressions and prevalent themes. In other words, themes were identified as those issues or topics which were discussed most frequently by participants;
- Thematic categories were conceptualized, developed and organized around patterns, phenomena, and prevalent issues based on the verbal categories used by participants and which arose repeatedly in the data. These patterns and themes continued to be sorted into categories as recurring regularities in the data continued to emerge. The thematic categories were later used to illustrate the resulting findings. The objective was to ensure that the data represented all of the diverse perspectives provided by participants. The intention was not to verify any preconceived hypothesis but to allow the themes to arise naturally from the data;
- These themes and patterns were conceptualized, organized and categorized under relevant category headings in the draft document;
- The data were organized and categorized in the draft document through a basic process of “cutting and pasting” using the MS Word for Windows program. In other words, when a relevant thematic category was identified, it was extracted or cut from the document and rearranged, inserted or pasted under the relevant thematic category heading in the same document;
- This process continued until all of the data were organized and categorized under its relevant category heading;
- The interpretation of the data was facilitated by the conceptual grouping of the data into themes and categories. All of the data was interpreted in order to determine the extent to which they generated meaning. This was done by noting patterns and themes, as well as assessing the extent to which the data made initial, intuitive sense; and
- The relevance of the data was also assessed by separating data that did not seem to fit any category.

IV. Results

The stress of migration, the stress of settlement: psychological & physical Implications:

Participants discussed the impact of pre-migration events on their mental, psychological and emotional health and well-being, including civil war, religious persecution and physical and psychological trauma, violence and abuse. Some of the most common health and mental health problems participants experienced as a result of these experiences include depressive symptoms, including clinical depression, post-traumatic symptoms, anger, anxiety, survivors guilt (particularly around family members suffering back home), feelings of worthlessness, substance dependence, insomnia, flashbacks, nightmares, problems concentrating, insecurity and feeling unsafe and somatic complaints.

One mental health professional who works with refugees pointed out that the challenges that many of these individuals experienced in their homelands make it difficult for them to integrate into Canadian society and to identify appropriate and effective coping responses after they have migrated to Canada.

Another discussed the impact of trauma on the health and mental health of migrants. discussed the need for mental health services to better reflect the unique experiences of racially and culturally diverse groups who have been faced with multiple challenges before migrating to Canada. Asserting that physical health problems tend to be less of a concern for these individuals than mental health problems and that their ongoing physical trauma and health problems such as pain or dismemberment of limbs are reminders of the trauma they experienced in their home countries.

According to this health professional post-traumatic symptoms do not often occur simultaneously and that individuals cope in very individualized ways. In addition the subjective experience of distress is often gender-specific since women and men are often tortured in unique ways, with women's torture often involving sexual violence and rape and men being faced with the psychological conflicts that result from being torn between various camps.

In discussing the pre-migration issues that impact on the mental health of undocumented Caribbean origin women who have been refused the right to stay in Canada, one respondent identified poverty, domestic abuse and childhood sexual abuse as the most pressing issues facing most of her clients. These experiences have left many of these women mistrustful of others, fearful and lacking in clear boundaries. For most of these women, family relationships are often one of the most significant factors in shaping their identities, with survival guilt being a common sentiment among those who migrated to Canada and have left family members back home in war-torn countries.

Dealing with Loss

One of the issues that participants in this study discussed most often were the family, material and symbolic losses they experienced migrating to Canada,

including being forced to leave family behind, the death of family members due to war, the loss of material items such as educational certificates, as well as the loss of their cultural identity.

For example, a Somali participant recalled in heart-wrenching detail her experiences leaving her home and being mistreated in camps in Kenya, losing documents and educational certificates, losing family members along the way as she traveled to safety (including her husband and her mother who was killed in a car bomb in Somalia), losing her sense of security and, finally, losing her culture and sense of identity. She also discussed the lasting emotional impact that the civil war has had on her children for whom rainy weather in Canada is now a signal to take shelter under their beds because it reminds them of gun bullets in their home country.

An Afghani participant also discussed how her decision to migrate to Canada resulted in her “losing everything”, including her family and her home. She discussed the pain of these losses, the challenges she experiences adjusting to life in Canada, as well as her ongoing depression.

A Sri Lankan participant recalled the years between 1986 and 1993 when she was forced to flee Sri Lanka with her husband, which was surrounded by government army at that time. She discussed the ongoing remorse and guilt she suffers today over her decision to leave her daughter behind in India while she and her husband reside safely in Canada.

An Ethiopian participant revealed that the mental health problems she suffers from today, such as difficulties concentrating and sleeping, the inability to recall past events and anxiety about family back in Ethiopia, can be directly linked to her failure to secure legal status in Canada.

Similarly, a participant from the Republic of the Congo discussed her ongoing emotional struggle over the loss of her seven children, who she was forced to leave behind when she decided to seek asylum in Canada due to the political crisis in her home country. She is currently taking medication to deal with depression and other mental health problems.

The Impact of Settlement Difficulties on Mental Health

Participants also discussed how settlement barriers and challenges in Canada impact on their mental health. The most common settlement barriers that migrants face in Canada include the experience of being in limbo as they await the granting of refugee status; culture shock; language barriers; difficulties accessing services and resources; problems children experience integrating into the school system; difficulties finding employment; skills upgrading; barriers obtaining accreditation for degrees and job skills; accessing education; lack of financial assistance for education; inability to secure housing and overcrowded dwellings; lack of proper housing; financial instability; role reversal within families that often result in children becoming caretakers and men often having to give up their positions as heads of the households; discomfort around leaving children in daycare; and isolation and discrimination and racism in Canadian society.

For many of these participants, these **settlement challenges often result in and are hampered by persistent mental health and health problems, including clinical depression; self-harm; suicidal ideation; paranoia; schizophrenia; psychosis; bi-polar disorder; anxiety; delusions; low self-esteem; substance use; gambling addiction (particularly for individuals dealing with poverty); loss of energy; gynecological problems; headaches; diabetes; high blood pressure; and insomnia.**

A service provider at Across Boundaries discussed how her own feelings of invisibility were accompanied by the shift in status that she experienced when she migrated to Canada, resulting in the damage to her sense of self-worth. According to this service provider, *“Back home you are somebody and here you are nobody”*.

Three health professionals argued that distinctions need to be made between the barriers, challenges and mental health problems that refugees, asylum-seekers and Canadian-born racialized experience in Canada.

For example, although individuals with refugee status are often relieved to have escaped violence in their homelands, they are confronted with new challenges in Canada that may result in increased rates of anxiety and stress. Asylum-seekers (non-status individuals), on the other hand, are often psychologically immobilized due to continuous feelings of restlessness and their inability or lack of interest in moving ahead with their lives.

Two health professionals noted that asylum-seekers are more likely to experience anxiety, fear and irritability due to their insecure status and inability to put down roots.

For those refugees who have been granted asylum, feelings of insecurity, financial instability, barriers accessing appropriate housing and training are the main issues they face. In addition, many of these individuals experience emotional turmoil and low self-esteem due to negative images of immigrants in the media.

One health professional pointed out that racialized Canadian-born individuals are also affected by the negative media images of their racial and cultural groups and communities, often resulting in these individuals internalizing these stereotypes and negative representations. Racialized and poor Canadian-born individuals may lack the level of resiliency that refugees and asylum seekers often display.

Other health professionals distinguished between the barriers facing refugees, asylum-seekers, and undocumented (non-status) long-term immigrants.

Pointing out that the legal status accorded to refugees provides them with a level of support and protection not given to undocumented long-term immigrants. Unlike those with refugee status, the undocumented person, whether they be recent arrivals or longer-term residents, are not acknowledged by the state and are, therefore, more likely to be vulnerable to exploitation by employers if they are working “under the table”. In addition, they often find it difficult to secure employment and access health services since their lack of legal status means that they are unable to obtain a health card or a social insurance number. Educational barriers were considered one of the more pressing issues and noted that clients often blame themselves and not the educational system for their inability to achieve academically. In fact many clients perceive Canada

as an equitable and fair country and lack a critical understanding of how racism operates in their lives. Moreover, many clients point to individual failings rather than systemic and structural barriers in explaining their inability to get ahead in Canada, which often results in high levels of anxiety and low self-esteem.

The importance of connecting with community was not lost on the mental health service providers who participated in this study.

One health professional discussed the ongoing isolation that many clients experience, an issue that is particularly pronounced for undocumented women whose status makes it difficult for them to develop and nurture meaningful connections and relationships with institutions, their community and other individuals.

Similarly, another health professional argued that the ability of migrants to integrate successfully in Canada will depend on the extent to which they are able to connect to a community in Canada. One of the advantages of living in a diverse society like Toronto is the ability to connect with people of one's own ethnic or cultural heritage. However, this could also pose barriers to these individuals if they "get stuck" in ethnic ghettos and are unable or unwilling to form connections to the wider social structures and community.

Two health professionals discussed the hesitance of and failure by some migrants and culturally diverse peoples to access mental health services.

Black women, in particular, tend to ignore the signs of mental distress, and particularly depression, for years until their physical and mental health are significantly impacted and are admitted to the emergency department with thoughts of suicidal ideation and severe anxiety. Many believe that irritability, insomnia, ongoing fatigue and loss of interest are normal. Many of these women also conceal the sexual molestation they experienced as children, as well as their current involvement in emotionally, physically and sexually abusive relationships. In addition, they often sacrifice their own emotional and physical needs in order to take care of and support family "back home" and in Canada, often without sufficient financial resources or domestic help.

One health professional pointed out that newcomers often have a stigma about mental illness and are, consequently, hesitant to seek out psychiatric or other mental health services. Consequently, they often find themselves in the hospital emergency departments when their problems have reached a crisis stage, particularly due to domestic violence and other serious family issues. Patients who are wary about revealing or admitting to mental health problems often tend to somatize their emotional problems by complaining about bodily ailments rather than emotional ones, such as headaches, stomach and bowel problems, heart palpitations and painful veins.

One psychiatrist offered an alternative perspective on the diagnosis of migrants and their coping skills. Questioning the usefulness of psychiatric services in resolving the emotional difficulties experienced by victims who have been displaced by war and is reluctant to classify these individuals as having a psychiatric impairment, particularly because it stigmatizes them. Although contending that these individuals may experience serious emotional distress, the respondent questions psychiatric presumptions that their experiences leave them dysfunctional. And argues that the most effective treatment for mental health problems produced by displacement involve

supportive services that assist these individuals with their daily living tasks, such as the proper processing of their papers, transportation, adequate food, housing, language training and a sense of stability. The ability of these individuals to navigate their worlds, as well as their willingness to rely on those environments, institutions and resources that offer them a sense of security, structure and comfort greatly alleviates the mental health difficulties resulting from experiences of displacement and torture.

Service providers at Across Boundaries discussed how the migrant experience may result in mental distress, frustration, aggression and violence, all of which may be misdiagnosed by psychiatrists who often undermine social causation (e.g. migration and settlement) in explaining mental health problems whilst emphasizing scientifically based and biological understandings of mental illness. They pointed out that many of their clients have not been pre-diagnosed with mental health problems before immigrating to Canada, much of it having to do with the stigma surrounding psychiatry and psychiatric labels in their home countries. They also noted that many of their clients who suffer from post-traumatic stress disorder due to experiences of war are often misdiagnosed with schizophrenia by psychiatrists. However, one psychiatrist pointed out that the diagnosis of schizophrenia is often useful for getting certain patients into treatment, particularly those who are unable to fit into certain treatment settings.

A male participant discussed how his experiences in a war-torn country resulted in his feelings of paranoia and frustration in Canada, as well as his belief that he is being “checked” (advised) or under surveillance by those in authority in Canada, including physicians and mental health professionals. He also discussed how his ongoing isolation has resulted in feelings of loneliness and depression in Canada. Many immigrant males also experience challenges adjusting to changes in gender and family roles and responsibilities when they lose their status as the main breadwinner in their families and when culturally prescribed traditions and norms about gender roles no longer have relevance in Canada.

A female participant stated that she was satisfied with how the Canadian government has provided for her basic needs. She identified lack of English language skills as the most significant factor in her inability to find employment in Canada, as well as the lack of community and family support in Canada.

Several participants identified inability to secure employment and contribute to Canadian society as factors that contributed to their emotional and mental health difficulties.

A participant who had been employed as an English teacher in her home country shared her frustrations about her inability to find employment in Toronto, her ongoing financial difficulties and her experiences with employment services and other service providers that refuse to acknowledge her educational qualifications and provide little guidance in assisting her in developing a resume. She revealed that her husband has been struggling with depression due to his inability to find work.

A female participant described how her mental health has been negatively impacted by flashbacks about past distressing events during the war in the Congo. She revealed that these flashbacks, as well her lack of status and inability to work in Canada

have resulted in insomnia, depression and a lack of self-worth. She likened herself to an “abandoned child” because of her inability to contribute to Canadian society.

Another participant discussed how various settlement barriers have impacted on her physical and emotional well-being. Some of these challenges include being put on a waiting list for housing, living in a two- bedroom apartment with two children and difficulties learning English. She described how her mental health problems impacted negatively on her children’s ability to study and the blame that her eldest son directs towards for his inability to study. She currently suffers from persistent ulcers due to the worsening of her mental health problems.

One service provider acknowledged that “Canada makes access difficult for newcomers”, but argued that those individuals who are able to “figure out” the system tend to have more success integrating into Canada and, consequently, fair better emotionally.

Another pointed out that the settlement difficulties that many newcomers experience in Canada could be greatly alleviated if they were to be provided with better quality housing, more nutritious food, suitable employment, access to daycare, language training and employment. For individuals who do not have access to daycare, securing employment is particularly difficult and for those who are working, they may be forced to accept low level and insecure jobs, many of which are paid “under the table”. This professional noted that the successful integration of newcomers is dependent on their level of resilience or religious and community involvement and support.

Yet another stated that it is difficult to determine if the settlement barriers that these individuals experience in Canada exacerbate the mental health difficulties that they experience due to distressing events back home. Health professionals were cautioned not perceive the emotional fragility produced by pre-migratory distressing events as an additive issue, but rather, as an issue that results from a multiplicity of events that operate simultaneously to affect the emotional and psychological well being of these individuals. **This professional stressed the importance of focusing more on how well people cope rather than on how badly they are suffering.**

Examining the Psychological Impact of Discrimination

Participants discussed the need to extend conventional understandings of “trauma” in the literature and psychiatry to include the ongoing emotional, psychological, spiritual and physical distress that asylum seekers, refugees, immigrants and Canadian-born racialized groups continue to suffer in Canada due to social exclusion, social inequality and discrimination.

One health professional argued that the concept of “trauma” should be re-conceptualized in ways that are more inclusive of not simply the experience of migration (torture, war, displacement, settlement), but also of “anything that affects or impacts the individual, including discrimination”. Some of the major barriers that prevent individuals from coping with discrimination and the migration experience are

- a) lack of support systems;

- b) misplaced family members due to war;
- c) family conflict and breakdown;
- d) peer pressure from other disenfranchised youth; and
- e) systemic and structural discrimination.

This health professional also contends that the establishment in the mental health system of a “hierarchy of trauma” that pits sexual assault against racial discrimination and other distressing events is one that should be challenged.

In addition discrimination that is not resolved in a timely manner may result in a host of health problems and violence against others and towards the self.

Another health professional noted that, in general, her Canadian-born racialized clients tend to have lower self-esteem than her clients who have immigrated to Canada. Low self-esteem of some of her clients was attributed to internalized discrimination, which often results in emotional problems. Many clients tend to blame themselves for their inability to achieve rather than structural and institutional inequalities and discrimination. Moreover, they often fail to question or challenge the negative labels (e.g. learning disability) that are often applied to them within the educational system and other institutions.

Service providers at Across Boundaries also argued that internalized racism also shows itself in the propensity for some racialized individuals to relinquish ties to their own cultural community. This phenomenon also works in reverse, with many recently arrived immigrants being ostracized when they attempt to develop connections with their own cultural community. Several explanations can be offered for this behavior, including a perception on the part of longer term residents that recent immigrants will become a burden on their community and Canadian society, in general, as well as feelings of superiority over recent immigrants who have yet to establish themselves.

One of the health professionals discussed the impact of discrimination on the mental health of her clients, most of whom are dealing with sexual orientation and sexual identity issues. The contention was that oppressed peoples have internalized oppression because they accept the stereotypes that others hold of them and believe the negative labels applied to people in their own cultural and racial community, all of which creates a self-fulfilling prophecy of failure and impedes achievement. Religion and “coming out” issues often converge in ways that impact negatively on the emotional well-being of some of her clients. For example, some Muslim and queer/lesbian clients have internalized the belief that they are sinful because they are living their lives as lesbians, particularly if they have accepted a particular interpretation of the Koran. Consequently, many of these clients struggle with a sense of loss from their decision to abandon their religion and faith and struggle with a variety of emotional and mental health problems resulting from internalized oppression, including low mood, anxiety and substance dependence.

Another health professional noted that clients who are struggling with sexual orientation and “coming out” issues often worry about experiencing discrimination from their own community and may live in fear about their own sense of safety if their community finds out about their sexual orientation.

There is a mental health impact of multiple oppressions for clients who are dealing with both racism and heterosexism from their partners, their families and the wider community.

One health professional discussed a mixed race client who was grappling with racism at work, discrimination from the heterosexual community and perceptions by members of her own community that she is not authentically Black.

In addition transgendered clients often discuss the challenges they face dealing with phobia from strangers.

Some racialized clients are grappling with racism from their non-racialized partners, many of whom are unable to recognize racism and other forms of oppression besides heterosexism.

An assertion from a health professional was that parents who are hetero-sexual may fail to equip their LGBTT children to cope with discrimination against gays and lesbians.

Another assertion from a health professional was that discrimination does not necessarily *cause* psychiatric problems but may exacerbate existing and long-standing mental health and psychiatric problems. Subtle and overt forms of discrimination may impact on the emotional well being of racialized individuals. Overt discrimination is often associated with angry responses, while subtle forms of discrimination may often lead to depression, particularly for individuals who have been frustrated in their attempts at social mobility. The mental health and well-being of individuals is dependent on how “well-integrated” they are, as well as their status within their own racial or cultural community.

Several participants discussed the emotional and mental health impact of overt and everyday discrimination, including conflicts with the police, employment discrimination, housing discrimination, perceptions that they lack intelligence because they are unable to speak English, negative attitudes from teachers due to their race, culture and religion and racial slurs.

For example, a Somali participant stated that everyday forms of discrimination have become part of her daily life. She discussed her encounters with condescending stares at the grocery store because she wears a hijab and believes that many White Canadians hold negative perceptions of immigrants, perceive them as outsiders and believe that they are a burden on taxpayers and are taking jobs away from Canadian-born individuals.

A black male participant discussed the everyday racism he experiences from customer service professionals and the police, including a customer service professional refusing to serve him at a burger establishment, the surveillance and over-monitoring he experiences from police officers, who randomly stop, frisk and arrest him and discriminatory treatment he has received from bus drivers, one of whom grabbed his transfer whilst allowing other passengers to enter the bus.

Although a participant of Eritrean background noted that the police have arrested him repeatedly, he believes that his inability to speak English has contributed to these arrests. According to this participant, “the problem is not discrimination but where to go to get help”.

Culturally Determined Beliefs about Mental Illness and Treatment

It is important that the Canadian mental health system begin to more effectively reflect the belief systems, practices and coping styles of culturally and racially diverse clients. Service providers at Across Boundaries discussed the “clash of norms” that often occurs when mental health professionals fail to understand culturally determined ideologies and behaviours of culturally diverse clients.

One health professional stated that some clients, particularly women of Caribbean heritage, believe that the negative and distressing life events they experience are caused by the past negative events committed by their ancestors. Many of these clients cope with emotional distress by relying on spirituality, their pastors and a higher power. They often discuss in counseling sessions how they are comforted in their dreams by spirits embodying relatives that have passed away. Women who attend church tend to heal faster and are better able to let go and move forward, which is often a deterrent from committing suicide. **In addition, church often replaces family support for women whose families are not in Canada.**

Culturally diverse women often somatize mental health problems by downplaying feelings of sadness and hopelessness and prefer to express distress through the presentation of physical symptoms, such as headaches, stomach problems and muscle pain. For example, Black women are typically not the type of patients that are breaking down, crying and complaining about their inability to cope. Rather, these women often take on “the strong Black woman” role, ignoring their distress and forging ahead with the care of their families and actively trying to manage their emotional difficulties with little support. The tendency of some psychiatrists to prescribe antidepressants to these women fails to acknowledge the pain and stress that are part and parcel of living in a racist, sexist, classist, homophobic, ageist, ablest society. **This health professional noted hesitancy in referring racialized women to mental health services because health professionals often lack an understanding of the multiple oppressions that Black women experience and are too eager to prescribe medication.**

Another health professional argued that the medical model is perceived as a more legitimate approach than indigenous approaches because of its dominant status and because the latter lacks scientific validity.

At Across Boundaries, the focus is on alleviating mental health difficulties by developing clients’ life and employment skills rather than prescribing medication. Many clients prefer services that offer them a sense of community and safety and provide them with information and referrals to other agencies, which allows them to effectively navigate the system.

Yet another health professional stated that most of her clients hold Western understandings of mental illness since they are Canadian-born or immigrated to Canada when they were very young. Moreover, while some of the clients are anti-psychiatry, others are not opposed to being labeled or diagnosed with a mental health problem or being prescribed medication.

Both the last two mental health professionals stated that their clients use a variety of approaches to cope with mental health problems, including religion and spirituality, support from friends, family and community, herbal medicine (e.g. St. John's Wart), yoga, home remedies (e.g. glass of warm milk and honey), acupuncture, various forms of complementary medicine.

A Somali participant pointed out that although there is a cultural belief that taking medication "will make you comatose", she often uses medication if all else fails. Finally, one health worker argued that mainstream mental health services that are overly concerned with identifying and applying a diagnosis tend to pathologize clients. Consequently, they "easily write off people" and over-use diagnoses such as borderline personality disorder. She also pointed out that racialized and LGBT clients often have negative experiences when they receive care from mental health services because the services are often very heterosexist and make assumptions that all clients are heterosexual. In addition, although there are mainstream programs that have high a proportion of racialized men, they have little understanding of how race and issues relating to racism should be incorporated into programs and service delivery. Consequently, she contends that " (such services) harm racialized peoples" in a number of ways, including misdiagnosing them and providing inappropriate treatment plans, failing to offer long-term therapy due to lack of resources and failing to ask questions about sexual orientation.

V. Discussion

The psychoanalytic emphasis on the complex and often painful transactions between the psychic and social can reveal how deeply racism permeates not only the institutions of post-colonial societies, but also the ways in which we experience ourselves and others

(Pajaczkowska and Young, 1992, p. 1998)

Discourse that confines discussions on "mental illness" primarily to biologically-based explanations may ignore and undermine the impact of socio-cultural context in producing and exacerbating mental health problems among racialized groups.

Limitations of the study

Regardless of the type of research that is being conducted, the research environment will involve power relationships between the dominant (researcher /interviewer) and the subordinate (participant). Given the focus on diverse community groups, many of whom feel marginalized because of ethno-racial, cultural, religious/faith, and sexual orientation, it was imperative that the researcher/interviewer strove to create, as much as was possible, an equitable and reciprocal research environment. The researcher /interviewer took various steps to reduce the power

imbalances during the research. First, she created an environment for focus groups and interviews that enabled participants to be self-reflective and to participate in the construction, interpretation and validation of their own worlds and experiences. She ensured that interviews and focus groups were reciprocal and collaborative. The pace and open-ended nature of interviews and focus groups encouraged participants to engage in a process that allowed them to reflect on, define and articulate their life circumstances on their own terms. The process also gave legitimacy to their cultural and religious worldviews and beliefs by validating participants as experts in their own lives and communities.

Trust is another issue that can impose limits on the data obtained in any research project, especially if there are differences between the researcher/interviewer with respect to socio-economic level, education, race, ethnicity, religion and sexual orientation. Lack of trust in the researcher/interviewer for these and other reasons may cause participants to distort reality by not sharing openly and honestly and by concealing knowledge, experiences and opinions. The researcher /interviewer in this research recognized how crucial it was at the outset to earn the trust of participants and to assist them in feeling comfortable to disclose their knowledge, opinions and experiences on issues that were often emotional and sensitive. One way in which she sought to increase participants' comfort level was to create a focus groups environment that was intimate, comfortable and relaxed. Focus groups were conducted within organizations from which participants received services and visited frequently. The researcher/interviewer was strongly cognizant of the fact that her own status as a racialized person might, in itself, engender a certain amount of trust and comfort from participants who, themselves, were racialized because of an assumption that she would have a certain amount of empathy for their experiences and concerns, which was certainly the case.

Although not necessarily a limitation, it is important to point out that generalizability of findings is not possible with qualitative research. The objective of qualitative research approaches, such as the one presented here, is to explore in detail the life experiences, opinions and attitudes of individuals and groups and not to make generalized assumptions or claims that are said to be representative of any population group.

Towards a re-conceptualisation of trauma

This study has argued that “trauma” needs to be re-conceptualized in ways that are more inclusive of experiences of discrimination and racism for new and long-term immigrants, refugees and the racialized native-born populations. More specifically, it has argued that conventional and Euro-Western understandings of “trauma” in the literature and in psychiatry must be extended in ways that acknowledge not only experiences of torture, but also the ongoing emotional, psychological, spiritual and physical distress that asylum seekers, refugees, immigrants and Canadian-born racialized groups suffer from in Canada due to social exclusion, social inequality and

discrimination. Although studies that examine the mental health difficulties that migrants experience integrating into Canadian society are much needed, their focus on conflicts in the home countries of these groups, as well as on the cultural dissonance that these groups experience in Canada undermines the centrality of discrimination and, particularly racism in producing mental health problems as found in the testimonies of our participants.

The study also adds to a growing body of research that conceptualizes discrimination, and particularly racism, as “assaultive”, “violent” and “abusive”. A central aspect of the study was identifying the links between the impact of state violence and the violence of structural, institutional and “everyday” discrimination and racism on the emotional, psychological mental, spiritual and physical health of racialized groups in Canada. State violence involves the impacts of trauma that refugees and asylum-seekers experience due to psychological and physical torture, war, religious persecution and other distressing events, while violence resulting from discrimination pertains to structural, institutional, everyday and internalized forms of discrimination that are inflicted upon racialized and other oppressed groups.

It is important to point out here that while the study does not seek to dismiss biological and genetic explanations for mental illness, it does argue that the propensity to “medicalize” forms of distress displayed by victims of torture and other racialized groups in the psychiatric community contributes to the on-going pathologizing of culturally and racially diverse groups and behaviours and coping responses that may be natural, normal and adaptive.

This study identified a number of issues that the mental health system should consider in developing mental health policies and services geared towards racially and culturally diverse peoples who are dealing with discrimination, inequality and exclusion due to race, culture, religion/faith, gender, sexual orientation and other social differences.

Therapeutic Relationship & Client Support

Given the importance of race and racism to the respondents in this research it would seem prudent to ensure that the issue of racism is front and center when dealing with the mental health issues facing racialized and other oppressed groups. However this is nuanced and there will need to be an acknowledgement that multiple oppressions operate in the lives of racialized and other oppressed peoples. Given that this is the reality of clients and the literature service providers will need to understand how to work with internalized oppression. Given the findings of this study it may be helpful for service providers to conceptualize discrimination as a form of trauma, to acknowledge the impact of discrimination (racism; heterosexism etc.) torture, trauma and settlement barriers on the mental health and well-being of racialized and other oppressed groups in Canada and to appreciate how racism and other forms of discrimination can exacerbate pre-existing mental health problems for victims of trauma, immigrants and Canadian-born groups.

This research sees these traumas as a social fact of life. This being so supports such as talk therapy peer support and other more practical therapeutic approaches would seem more appropriate than the prescribing of medication. If the route cause is a social problem then assisting clients in coping with major life issues, such as barriers to employment and housing will be important in improving their mental health. This will, require holistic and individual assessment that acknowledge the multiple ways that individuals cope with mental health problems, including religion and spirituality and community and family support systems. However the literature and our participants demonstrate that the links between state violence and ongoing discrimination can have long term impacts. Because of this practitioners will need to consider needs assessments on an on-going basis to determine the impacts of trauma for victims.

Service Delivery

Psychiatry reflects society and society can be racism. The models used in psychiatry are from one cultural group and they need to be challenged. Diversity in the work force may improve service delivery but will not improve the models of service delivery. Diversity in service providers through multi-sectoral partnerships with settlement agencies, social service and community agencies, shelters and other institutions in the community may be important in offering different illness models that can embrace the challenge of the discourse of racism and trauma. For the mainstream the results of this research may be useful as a basis for developing training and workshops to educate health professionals on how to incorporate discrimination and racism within the language of trauma, along with more conventional understandings of trauma such as sexual abuse and victimization due to torture.

There is clear need from the participants for more trauma services for refugees in Toronto that allow clients to discuss trauma in a safe way. Settlement agencies could be encouraged to acknowledge health and mental health issues as central to their service delivery and policy development. Better links between settlement agencies and health could offer them support and training as well as developing pathways to care for their clients. This would of course be helped by government providing health coverage for refugees.

REFERENCES

- Abbott A.A. (1995). Repetitive life patterns and coping with the crisis of unemployment. In A.R. Robbers (Ed.), *Crisis Intervention and Time Limited Cognitive Treatment* (pp. 188-214). New York: Sage.
- Access Alliance Multicultural Community Health Centre (April 2007) *Racialization and health inequalities: Focus on children*. Toronto: Access Alliance Multicultural Community Health Centre.
- Across Boundaries. (1997). *A guide to anti-racism organizational change in the health and mental health sector*. Toronto: Across Boundaries.
- Ali, J.S; McDermott, S.; & Gravel, R.G (2004, May-June) Recent research on immigrant health from statistics Canada's population surveys, *Canadian Journal of Public Health*, 95(3), 9-13
- Baldwin, J.A. (1980). The Psychology of oppression. In M. K. Asante & A. S. Vandi (Eds.), *Contemporary black thought: Alternative analyses in social and behavioural science* (pp. 95-110). London: Sage Publications.
- Berthold, S.M; Wong, E.C; Schell, T. L; Marshall, G.N; Elliott, M.N; Takeuchi, D. T; & Hambarsoomians, K. (2007, September). U.S. Cambodian refugees' use of complementary and alternative medicine for mental health problems, *Psychiatric Services*, 58, (9), 1212-1218.
- Bhugra, D., Leff, J, Mallett, R, Der, G, & B. Corridan.(1997). Incidence and outcome of schizophrenia in whites, African Caribbeans and Asians in London, *Psychological Medicine*, 27, 791-798.
- Bojuwoye, O. (2005). Traditional healing practices in Southern Africa: Ancestral spirits, ritual ceremonies, and holistic healing. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counselling and psychotherapy* (pp. 61-72). Thousand Oaks, CA: Sage Publications.
- Bryant-Davis, T. & Ocampo, C. (2005). Racist incident-based trauma, *The Counseling Psychologist*, 33 (4), 479-500.
- Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees (1988). *After the door has opened: Mental health issues affecting immigrants and refugees in Canada*. Ottawa: Minister of Supply and Services Canada.
- Clark, R., Anderson, N.B., Clark, V.R. & Williams, D.R(1999). Racism as a stressor for African Americans: A biopsychosocial model, *American Psychologist*, 805-816.
- Fanon, F. (1963). *The wretched of the earth*. New York: Grove Press.
- Fernando, S. (1991). *Mental health, race and culture*. London: Macmillan Education Ltd.
- Fernando, S. (1992). Roots of racism in psychiatry. *Openmind*, 59, 10-11.

- Foster, G. M., & Anderson, B. G. (1978). *Medical anthropology*. New York: John Wiley and Sons.
- Foucault, M. (1965) *Madness and civilization: A history of insanity in the age of reason*. New York: Random House.
- Foucault, M. (1975). *Birth of the clinic: An archaeology of medical perception* (A. M. Sheridan Smith, Trans.). (1st Vintage Books ed.). New York: Vintage Books. (Original work published 1973).
- Foucault, M. (1979). *Discipline and punish: The birth of the prison* (A. M. Sheridan, Trans.). (1st Vintage Books ed.). New York: Vintage Books. (Original work published 1977).
- Fenta, H.; Hyman, I.; & Noh, S. (2007, October) Health service utilization by Ethiopian immigrants and refugees in Toronto, *Journal of Immigrant and Minority Health*, 9(4), 349-57
- Fernando, S., Ndegwa, D., & Wilson, M. (1998). *Forensic psychiatry, race, and culture*. London: Routledge.
- Gee, E.M.; Kobayashi, K.M.; & Prus, S.G. (2004). Examining the healthy immigrant effect in mid-to later life: Findings from the Canadian Community Health Survey, *Canadian Journal on Aging*, 23(Suppl1), S61-S69.
- Gilvarry, C.M., Walsh, E., Samele, C, Hutchinson, G., Mallett, R., Rabe-Hesketh, S., Fahy, T, van Os, J, & R.M. Murray (1999). Life events, ethnicity, and perceptions of discrimination in patients with severe mental illness, *Social Psychiatry and Psychiatric Epidemiology*, 34, 600-608.
- Glaser, B.G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.
- Halli, S.S.; Anchan, J.P. (2005, Winter) Structural and behavioural determinants of immigrant and non-immigrant health status: Results from the Canadian Community Health Survey, *Journal of International Migration and Integration*, 6 (1), 93-122.
- Harding, S. (1987). Introduction: Is there a feminist method? In S. Harding (Ed.), *Feminism and methodology: Social science issues* (pp. 1-7), Bloomington, IN: Indiana University Press.
- Haws, R.A. (2005, October). Migrations and gradations: reappraising the health profile of immigrants to Canada, *Kinesiology Abstracts*, 18 (2), [np].
- Hickling, F.W. & Rodgers-Johnson, P. (1995). The incidence of first contact schizophrenia in Jamaica, *The British Journal of Psychiatry*, 167, 193-196.
- Hyman, I. (2003, Fall). Canada's 'healthy immigrant' puzzle - A research report, *Women & Environments International Magazine*, 31-33.
- Karlsen, S. & J. Nazroo (2002, April). Relation between racial discrimination, social class, and health among ethnic minority groups, *American Journal of Public Health*, 92 (4), 624-631.

- Karlsen, S.; Nazroo, J.Y; McKenzie, K; Bhui, K; & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England, *Psychological Medicine*, 35, 1795–1803.
- Landrine, H. & Klonoff, E.A. (1996, May) The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences, *Journal of Black Psychology*, 22 (2), 144-168
- Lather, P. (1986). Research as praxis, *Harvard Educational Review*, 56 (3), 257-274.
- Lazarus, R.S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Mahoney, M. J. (1996). Connected knowing in constructive psychotherapy. In N. R. Goldberger, J. M. Tarule, B. M. Clinchy, & M. F. Belenky (Eds.), *Knowledge, difference and power: Essays inspired by women's ways of knowing* (pp. 126-147). New York: Basic Books.
- McClintock, A. (1995). *Imperial leather: Race, gender, and sexuality in the colonial contest*. London: Routledge.
- McKenzie K. & Bhui K (2007). Institutional racism in mental health care, *British Medical Journal*, 334, 649 - 650.
- Meyer, I.H. (2003, February). Prejudice as stress: Conceptual and measurement problems, *American Journal of Public Health*, 93 (2), 262-265.
- Morris-Prather, C.E., Harrell, J.P., Collins, R., Jeffries-Leonard, K.L., Boss, M. & Lee, J.W.(1996). Gender differences in mood and cardiovascular responses to socially stressful stimuli. *Journal of Ethnicity and Disease*, 6, 109-122.
- Nobles, W. W. (1976). Black people in White insanity: An issue for Black community mental Health, *Journal of Afro-American Issues*, 4 (1), 21-27.
- Noh, S.; Kaspar, V. & Wickrama, K.A.S. (2007, July). Overt and subtle racial discrimination and mental health: Preliminary findings for Korean immigrants, *American Journal of Public Health*, 97 (7), 1269-74.
- Ommeren, M.V., Saxena, S., & Saraceno, B. (2005, January). Mental and social health during and after acute emergencies: Emerging consensus, *Bulletin of the World Health Organization*, 83 (1), 71-77.
- Os van, J., Castle, D.J, Takei, N, Der, G. & R.M. Murray (1996). Psychotic illness in ethnic minorities: clarification from the 1991 census. *Psychological Medicine*, 26, 203-208.
- Outlaw, F.H. (1993) Stress and coping: The influence of racism on the cognitive appraisal processing of African Americans, *Issues in Mental Health Nursing*, 14, 399-409.

- Pajaczkowska, C., & Young, L. (1992). Racism, representation, psychoanalysis. In J. Donald and A. Rattansi (Eds.), *'Race', culture and difference* (pp. 198-219). London: Sage Publications.
- Raphael, D. (2007). Poverty and the modern welfare state. In D. Raphael (Ed.), *Poverty and policy in Canada: Implications for health and quality of life.* (pp. 5-26). Toronto: Canadian Scholars Press. First Edition.
- Rutter, M. (1993). Resilience: Some conceptual considerations, *Journal of Adolescent Health*, 14, 626-631.
- Schulz, A.J., Williams, D.R., Israel, B.A., Becker, A.B., Parker, E.A., James, S.A., & Jackson, J. (2000). Unfair treatment, neighbourhood effects, and health in Detroit metropolitan area. *Journal of Health and Social Behaviour*, 41 (3), 314-332.
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas, *Social Science & Medicine*, 48, 1449-1462.
- Sweet, M. (2007, Winter) Tackling discrimination is good for health, *VicHealth Letter*, 30, 5-7.
- Thomas Bernard, W. (2003). Black women's health in Nova Scotia: One woman's story. In S. Harding (Ed), *Surviving in the hour of darkness: The health and wellness of women of colour and indigenous women* (pp. 47-67). Calgary: Calgary University Press.
- Torrey, E. F. (1986). *Witchdoctors and psychiatrists: The common roots of psychotherapy and its Future.* New York: Harper & Row Publishers.
- Waldron, I.R.G. (2002). *African Canadian women storming the barricades!: Challenging psychiatric imperialism through indigenous conceptualizations of mental illness and self-healing.* Doctoral thesis, University of Toronto.
- Waldron, I.R.G. (2002) The power of knowledge: Resisting psychiatric imperialism through African indigenous conceptualizations of mental illness", *Endarch: Journal of Black Political Research*, 19-35.
- Waldron, I.R.G. (2003). Examining beliefs about mental illness among African Canadian women. *Women's Health & Urban Life: An International and Interdisciplinary Journal*, 2 (1), 42-58.
- Waldron, I.R.G. (2005). African Canadian women resisting oppression: Embodying emancipated consciousness through holistic self-healing approaches to mental health. In G. S. Harding (Ed), *Surviving in the hour of darkness: The health and wellness of women of colour and indigenous women* (pp. 13-31). Calgary: University of Calgary Press.
- Wilkins, R., Berthelot, J.M., & Ng, E. (2002). Trends in mortality by neighbourhood income in urban Canada from 1971 to 1996, *Health Reports*, 13 (Supplement), 1-28.

Women's Health Surveillance Report (2004) *Integrating ethnicity and immigration as determinants of Canadian women's health*. Ottawa: Canadian Institute for Health Information.

Wright, B. E. (1974). The psychopathic racial personality. *Black Books Bulletin*, 2, 25-31.

Wu, Z.; Schimmele, C.M. (2005) The healthy migrant effect on depression: Variation over time?, *Canadian Studies in Population*, 32 (2), 271-295.

APPENDIX A

Focus Group Questionnaire

Description of Research

The research looks at the challenges/barriers that immigrants, refugees and Canadian-born people who are visible minorities face as newcomers or as people who have lived here all of their lives. The focus is on how these issues impact on the physical, emotional and spiritual health and well-being of these groups. Our objective is to identify the factors that mental health agencies must consider in developing and implementing services for racialized groups, including victims of trauma.

We are specifically interested in hearing about how experiences of trauma and other difficult situations in your home countries, as well as experiences of discrimination in Canada impact on your physical, emotional, psychological and spiritual health.

Finally, we want to know about your experiences accessing health and mental health services to cope with and treat physical and mental health problems.

Please note that your names and identities will be kept confidential and will not be identified in the report.

Pre-Migration

Where were you born?

For those who were born outside of Canada, why did you leave your homeland and come to Canada?

How long have you been in Canada/Toronto?

What are some of the challenges you faced in your homeland? Did you face any of the following: war, religious persecution, violence and abuse etc.?

Did these events have an impact on your physical, emotional, psychological and spiritual health and well-being? If they did, can you explain how they impacted you?

Settlement

Have you continued to suffer from those challenges in Toronto?

For those of you who are Canadian-born and have lived here all or most of your life, what are some of the on-going challenges you face in Canada and how does this impact on your physical, emotional and spiritual health and well-being?

Have you experienced any difficulties as an immigrant trying to adapt to Canadian society?

How have you dealt with the difficulties you experienced as an immigrant in this country?

What have been your experiences accessing the following and how has it impacted on your emotional and physical well-being: a) employment; b) housing; c) childcare; d) education and training; e) language training

How do you think the following groups are perceived in Toronto/Canada?: visible minorities and visible minority women; immigrants and immigrant women.

What impact do these perceptions have on you?

Have you experienced discrimination in Toronto/Canada due to race, gender, culture, religion/faith, nationality, language, sexual orientation, ability/disability; education level, immigrant and refugee status, SES? Please discuss.

How have all of these experiences impacted on your physical, emotional and spiritual health and well-being, in general.

Post-Migration (6-10 years after immigrating)

There is an expectation that immigrants and refugees are eventually able to settle successfully in Canada 6-10 years after immigrating. Would you say that this is the case for you?

Do you still face challenges integrating into and accessing services in Canadian society/Toronto? What are these challenges?

How have these ongoing challenges affected you physically, emotionally, psychologically and spiritually?

Conceptualizations of Mental Health Problems

Have you or do you suffer from any health or mental health problems, e.g.: stress, hypertension, fear, anger, depression, anxiety, isolation, abandonment, trouble sleeping, trouble coping, helplessness, hopelessness.

What do you think causes mental health problems?

Do you believe that the challenges and experiences of discrimination you have faced have contributed to your health and mental health problems?

What do you think are the best ways to deal with mental health problems?

How have you dealt with these problems? Has it been effective?

Accessing Health Institutions

How have you or do you get information about available mental health services?

What are some of your reasons for accessing a mental health service like Across Boundaries?

Describe the experiences you have had accessing (incl. searching for) services in the community to help you deal with your concerns.

What kind of mental health service provider are you getting help from? (counsellor, psychiatrist, social worker etc.)?

What is your opinion of the effectiveness of the treatment, interventions and services you have received since you have been in Toronto?

Do you believe that mental health services in Canada effectively address past and current experiences of immigrants and refugees?

What are some of the issues that need to be considered in developing and providing services for racialized peoples, immigrants and refugees?

What are the issues that need to be considered when developing services for individuals who have suffered trauma in their homelands and continue to be traumatized due to racism and discrimination here in Canada?

Other Approaches for Dealing with Mental Health Problems

Describe other approaches or agencies that you have used to deal with mental health and health problems due to discrimination (settlement agencies, community agencies, family, social network, church/religion/higher power, support groups etc)

Have these approaches been effective? Why or why not?

Would you say that these approaches or agencies acknowledge the issues facing refugees and immigrants in Canada, with respect to trauma and discrimination?

Do you use these approaches in tandem with professional services (mental health services, psychiatrists, doctors etc)?

APPENDIX B

Interview Guide

Description of Research

Many immigrants and refugees come to Canada to escape extreme poverty, abuse, violence or war but many also experience trauma because of the impact of racism, social exclusion and other forms of discrimination that they experience in this society. Treatments and interventions associated to trauma have been very limited to specific experiences and population. Trauma victims from racialized communities have not been able to access appropriate mental health services that address past and current experiences and as a result continue to either not access the current mental health system at all or access only when in crisis. Inadequate trauma services for new immigrant and refugee communities is a need that is identified not just in the mental health system but by many settlement and community agencies. Staff training in trauma-related issues and responses is much needed in order to adequately address the needs of victims of trauma from racialized communities.

The research looks at the challenges/barriers that immigrants, refugees and Canadian-born people who are visible minorities face as newcomers or as people who have lived here all of their lives. The focus is on how these issues impact on the physical, emotional and spiritual health and well-being of these groups. Our objective is to identify the factors that mental health agencies must consider in developing and implementing services for immigrants and refugees in Canada.

We are specifically interested in hearing about the physical, emotional and psychological impact of trauma for these groups, including trauma in home countries due to war, persecution etc, as well as the trauma they continue to face due to discrimination and exclusion in Toronto/Canada.

Finally, we want to know about their experiences accessing health and mental health services, community and settlement agencies and other resources to cope with and treat physical and mental health problems.

Please consider the following 3 categories in responding to the questions: 1) asylum seekers who experienced trauma; 2) those granted refugee status and continue to experience trauma (poverty, racism, Islamophobia; 3) Canadian-born racialized people who experience trauma (racism and poverty)

Biographical

What is the name of your agency/organization?

What is your position title/what is your profession?

Which ethnic, racial, religious or linguistic groups do you provide services to?

How many years have you been working with these groups?

Pre-Migration

What are some of the challenges members of these groups face in their homelands?

How do experiences of psychological and physical trauma (war, persecution, terrorism etc.) impact on the physical, emotional, psychological and spiritual health and well-being of immigrants and refugees?

Are there distinctions among the following two groups with respect to the physical, emotional, psychological and spiritual health and mental health impact of trauma:

1) asylum seekers who experienced trauma; 2) those granted refugee status and continue to experience trauma (poverty, racism, Islamophobia)

Settlement

What would you say are the most pressing issues facing racialized, immigrant and refugee groups in Canada? (employment; housing and neighbourhoods; childcare; education and training; language training)

How do these challenges impact on their health, emotional well-being and mental health?

Describe how their experiences with discrimination have impacted on their physical, emotional and psychological health and well-being (race, gender, culture, religion/faith, nationality, language, sexual orientation, ability/disability; education level, SES)

Post-Migration (6-10 years after immigrating)

There is an expectation that immigrants and refugees are eventually able to settle successfully in Canada 6-10 years after immigrating. Would you say that this is the case for many of them?

Would you say that immigrants, refugees and victims of trauma continue to suffer the physical, emotional, psychological and mental health ramifications of pre-migration experiences?

What would you say are the barriers that prevent them from coping with or resolving these issues?

Diagnosing and Treating Mental Illness & Mental Health Problems

Do you believe that conceptualizations of trauma for asylum-seekers, refugees and victims of trauma, in general, should extend to the trauma these individuals suffer due to discrimination and racism in Canada?

What would you say are the most common health and mental health problems experienced by racialized peoples, immigrants and refugees/victims of trauma?

How do they conceptualize mental illness or what are their belief systems about mental health problems and treatment?

How do these clients present symptoms of mental illness?

Which types of services and treatments do these groups utilize to cope with and/or resolve mental health problems?

How do these individuals respond to these treatment approaches?

What is your opinion of the effectiveness of the treatment, interventions and services you have received since you have been in Toronto?

What are the reasons why a resource/service may or may not be used by these groups?

How do the following issues influence the type of treatment or sources of assistance these groups access: race, culture, gender, immigrant and refugee status, Canadian-born vs. immigrant/refugee, SES, education, language, religion/faith, sexual orientation, disability, age?

Do you believe that mental health services in Canada effectively address past (trauma due to war etc) and current experiences (discrimination, racism etc) of immigrants and refugees?

What are some of the issues that need to be considered in developing and providing services for racialized peoples, immigrants and refugees who suffer past and current experiences of trauma?

What types of policies need to be implemented in order to ensure that the experiences, perspectives and beliefs held by these groups are integrated into mental health service delivery in Canada?

