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Welcome

CALD Child and Adolescent Mental Health – A Resource for Health Providers is written for health providers caring for Asian, Middle Eastern and African children and young people and their families. The resource has been developed to increase health provider’s cross-cultural knowledge, awareness and skills in working with Culturally and Linguistically Diverse (CALD) children and young people and their families in the context of mental health care.

As New Zealand becomes increasingly ethnically diverse, we need to ensure that we work towards Child and Adolescent Mental Health Services that are effective for CALD families. Culture and religion play a major role in the way that families perceive and respond to mental health concerns. As well, understanding the stressors of migration, refugee resettlement and acculturation is helpful in providing culturally competent assessment, intervention and support for CALD children, young people and their families.

There is growing evidence that culturally adapted mental health interventions improve engagement and outcomes for CALD clients and families. To be clinically effective, health practitioners need to be knowledgeable about Asian, Middle Eastern and African family values, norms and traditions, be flexible in their therapeutic approaches, and create an atmosphere in which both parents and children feel valued and respected. This resource provides the tools to support practitioners in this endeavour.
What this resource aims to do

This document aims to provide cultural information on child and adolescent mental health issues for CALD clients and families. It is not a stand-alone document and it is assumed that the viewer has an understanding of the following from the learning programme ‘CALD 9; Working in a Mental Health Context with CALD Clients’ (Waitemata DHB eCALD ® services, 2012):

- The common issues and concepts that are involved in cross-cultural assessment.
- Explanatory models of illness.
- What we mean by 'somatisation' when working with CALD clients.
- Culture-bound syndromes.
- The DSM-V’s criteria for Developing a Cultural Formulation for Diagnosis.
- Appropriate screening instruments and assessment tools, and issues related to these when working with CALD children, adolescents and families.
- How to collaborate in intervention and treatment with CALD clients and families.
- Ethnopharmacology.
- Familiarity with CALD Assessment Tools.

This resource provides a summary of current literature and guidelines for practitioners who work with CALD children and adolescents and their families.

The information in this resource reflects traditional values and practices that may not be relevant to all families, nor to some immigrant and second-generation clients, nor to the younger generations. It cannot be stressed strongly enough that in order to avoid stereotyping, this culture-specific information is useful as a platform only for exploring clients' unique needs and experiences.

Purpose

The purpose of this resource is to support services and practitioners providing mental health care for CALD children, young people and families develop the knowledge, skills and attitudes needed to provide culturally competent assessment, intervention and treatment for these groups.
Who this resource is for

This resource is for health providers who are involved in caring for Asian, Middle Eastern and African children and young people with mental health related issues in primary, community, mental health, and secondary care settings. The resource complements the CALD Cultural Competency Training Programme provided by WDHB eCALD® Services (for more information go to www.ecald.com). NB CALD in this resource refers to culturally and linguistically diverse groups from Asian, Middle Eastern and African backgrounds.

It is highly recommended that the viewers of this resource will have completed the CALD 1: Culture and Cultural Competency course available via www.eCALD.com.

It is expected that viewers of this resource will:

1. **Have completed CALD 1: Culture and Cultural Competence**
2. **Additionally, it is highly recommended that the readers of this resource will:**
   - Have completed CALD 2: Working with migrants (Asian) patients [course].
   - Have completed CALD 3: Working with refugee patients [course].
   - Have completed CALD 4: Working with interpreters [course].
   - Have completed CALD 10: Working in a mental health context with CALD children and adolescents [course].

Additional valuable information on working in a culturally competent way with migrants, refugees and interpreters can be found in the following courses and supplementary resources all available via www.eCALD.com under Resources.

- CALD 5: Working with Asian mental health clients [course].
- CALD 7: Working with religious diversity [course].
- CALD 8: Working with CALD families - Disability Awareness [course].
- **Supplementary resources with culture-specific information, case scenarios, tips, guidelines and approaches to supplement the above courses:**
  - Cross-Cultural Resource for Health Practitioners working with CALD clients-patients [pdf].
  - Ayurvedic Medicine [video].
  - Working with Religious Diversity [HTML object].
  - Working with CALD families - Disability Awareness [HTML object].
  - Working with Asian mental health clients [HTML object].
  - Working with Middle Eastern and African mental health clients [HTML object].
  - CALD Family Violence Resource for Health Practitioners: Working with Asian, Middle Eastern and African women [pdf, HTML object].
  - Maternal Health for CALD Women: Resource for health providers working with Asian, Middle Eastern and African women [pdf, HTML object].
Out of Scope

This resource is specifically focused on mental health care for CALD children, adolescents and their families.

Specific information on maternal mental health, family violence and CALD mental health care for adults are covered in the following resources:

- *Maternal health for CALD women: Resource for health providers* available in PDF and HTML formats (Waitemata DHB eCALD® services, 2016a).
- *Working with Asian mental health clients* (Waitemata DHB eCALD® services, 2010).
- *Working with Middle Eastern and African Mental health clients* (Waitemata DHB eCALD® services, 2013).
- *CALD Family Violence Resource for Health Practitioners* (Waitemata DHB eCALD® services, 2014a).

How this resource is organised

**Welcome:** Provides an overview of what this resource is designed to achieve and its scope. A summary of cross cultural skills for working with CALD children, young people and their families and guidelines for engaging with Asian, Middle Eastern and African families are included.

**Introduction:** Provides background information including some facts about Asian, Middle Eastern and African populations, the migrant and refugee experience, a summary of system and service barriers, the cross-cultural skills required for working with CALD children, adolescents and their families, as well as an overview of collective cultural values and suggested culturally appropriate approaches.

**Assessing migrant and refugee children and adolescents:** Explores cultural differences in relation to child rearing practices and growth and development expectations for children and young people. Outlines cultural considerations in assessment, and information relating to intergenerational conflict, as well as tools for assessing migrant and refugee children and adolescents including: validated screening tools; ethnic differences in DSM classifications; and the DSM V Cultural Formulation tool; and a case scenario for discussion.

**Cultural presentations of distress:** Discusses cultural presentations of distress including somatic symptoms and culture-bound syndromes.
**Help-seeking behaviours:** Explains CALD family's patterns of response to mental health, coping mechanisms and help seeking behaviours from both western and traditional healing services; and how to engage with families.

**Common conditions:** This section provides cultural information on common mental health disorders presenting to Child and Adolescent Mental Health Services (CAMHS). Case scenarios are provided to demonstrate good practice.

**Psychosocial interventions:** Information on culturally appropriate psychosocial interventions including cognitive-behaviour therapy, family therapy, psychoeducation, strengths-based approaches and collaborative mental health care for refugee children. Case scenarios to demonstrate good practice are included.

**Appendices:** The appendices provide cross-cultural mental health information for health providers, translated mental health psycho-education information for consumers and a list of child and youth refugee and migrant services.
Introduction

Culturally competent mental health care for CALD children, young people and their families is central to the provision of quality, equitable and responsive services. Cultural competence includes health practitioners developing cultural awareness, sensitivity, knowledge and skills.

Being aware of the barriers to accessing health services for Asian families, and how to overcome these, is helpful in ensuring that families remain engaged with service providers and with the treatments and interventions prescribed. As well, being familiar with collective family values, traditional health beliefs and practices, perceptions of health and illness and expectations of healthcare, will reduce cultural conflict between families and practitioners. Gaining skills in cultural assessment including: assessing cultural views, behaviours, practices and expectations; and the ability to negotiate a culturally and mutually acceptable outcome, will improve service uptake, treatment compliance, patient experience and reduce misunderstanding and disengagement.

Asian, Middle Eastern and African populations

The Auckland region is superdiverse with more than 200 ethnic groups settled in the region. In this resource, the term ‘Asian’ refers to the collective set of Asian ethnic groups, who although not homogeneous in nature, share certain value orientations, health beliefs and practices. These groups represent many diverse cultures, languages, religions, socio-economic status, education levels and migration experiences. Asian peoples in New Zealand come from countries in West Asia (Afghanistan and Nepal), South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong and Japan), and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Kampuchea) (Mehta, 2012).

‘Asian’ groups include every category of immigrant: skilled migrants; refugees; those on temporary work visas, foreign fee-paying students on fixed term visas; and New Zealand-born Asians (third and fourth generation New Zealanders).

New Zealand-born Asians and 1.5 generation Asians (who were born overseas and relocated to New Zealand at a young age) are generally more acculturated to New Zealand culture, than newcomers. Within a family, the degree of acculturation may vary between the younger generation and the older generation or between those who have longer residence in New Zealand and those who are new arrivals.
Asian, Middle Eastern and African populations have much younger age structures than European populations, with relatively high proportions at the child and childbearing ages, and low proportions at the older ages (SNZ, 2015).

Annually, the New Zealand government accepts a UNHCR mandated refugee quota of 750 places. In 2018, this number will increase to 1000 quota refugees per annum. Refugees also arrive as asylum seekers and through the refugee family sponsored category. A quarter of refugee populations are under the age of 15 years (McLeod & Reeve, 2005). Rungan et al’s (2013) study of refugee children under five, arriving in New Zealand includes: children from: Myanmar (40%), Bhutan (10%), Afghanistan (8%), Congo (6%), Eritrea (4%); Colombia (13%) and Iraq (7%); with Sudan, Burundi, Sri Lanka, Iran, Indonesia, Palestine, Mauritius. Rwanda, Nepal, Somalia and Bangladesh each less representing less than 2% of children arriving from January 2007 to January 2012.

**Asian people**
The Asian population in the Auckland Region was over 402,000 in 2016 representing 23% of Auckland’s total population (SNZ, 2015). The most predominant Asian ethnicities in the region are Chinese (38.5%); Indian (34.6%), Korean (7.2%) and Filipino (7.0%) peoples. Close to a quarter of Asian peoples in the Auckland region have lived in New Zealand for less than 5 years (Walker, 2014).

Asian peoples in New Zealand come from: South Asia: India, Sri Lanka, Nepal, Pakistan, Bangladesh, Afghanistan, Bhutan, the Maldives and Fijian Indians. East Asians include people who have migrated from China, Japan, Taiwan, Mongolia, South Korea, North Korea and Macau. South East Asians include people from Vietnam, Cambodia, Malaysia, Singapore, Indonesia, Thailand, Philippines, Burma, Brunei, East Timor, and Laos (Mehta, 2012).

**Middle Eastern and African people**
Middle Eastern and African (MEA) populations consist of extremely diverse groups with dissimilar cultures, religions and backgrounds. In 2013, 2% (44, 259) of the New Zealand population identified as Middle Eastern, Latin American and African (MELAA) and half lived in the Auckland region (Walker, 2014).

**Middle Eastern people**
Middle Eastern people are the largest of the MELAA groups in Auckland. Middle Eastern peoples in New Zealand come from: Algeria, Egypt, Iran, Iraq, Israel, Jordan, Lebanon, Libya, Morocco, Oman, Palestine, Syria, Tunisia, Turkey, Yemen, Kuwait, the United Arab Emirates, Turkey, Saudi Arabia and Bahrain.

Since 1994, refugees from Iran and Iraq have formed a large proportion of New Zealand’s refugee intake and overall these groups make up the largest Middle Eastern populations
These ethnic groups represent many diverse languages, religions and ethnic affiliations.

African people
African people are the second largest MELAA group in Auckland. Similar to Middle Eastern people, many came to New Zealand as refugees from the late 1980s (predominantly from the Horn of Africa). By the early 2000s, the majority came as migrants from South Africa and Zimbabwe (Perumal, 2011).

African peoples in New Zealand are from: Jamaica, Kenya, Nigeria, the USA, Uganda, The Caribbean, Somalia, Eritrea, Ethiopia, Ghana, South Africa, Zimbabwe, Democratic Republic of Congo, Republic of Congo, Tanzania, Rwanda, Burundi, Nigeria, Sierra Leone, Djibouti and Sudan. African peoples come from diverse cultural and religious backgrounds and ethnic affiliations.

The impact of the migrant and refugee experience
Migrant children and young people are at risk of mental health problems. The migration process causes stress, not only because migration entails extensive loss of family and friends, culture and community, but also because migrants have to adapt to a new cultural environment, often including different social norms, values and standards and a new language (Berry, 1990). The New Zealand Youth 2007 study found that mental health issues were a significant concern among Asian youth, especially among female students (Parackal, Ameratunga, Tin Tin, Wong & Denny, 2011).

Research shows that refugee youth are at considerable risk of developing mental illness and experiencing co-morbid disorders, such as depression and anxiety (Pumariega, Rothe & Pumariega, 2005; Schweitzer, Melville, Steel & Lacherez, 2006; Te Pou, 2008). Refugee children and young people are at increased risk of mental illness due to: pre-migration experiences, including: war, physical injury and sexual assault, family separation, refugee camp life with its daily struggle for survival, disempowerment and decreased safety, violence and atrocities, extreme poverty and deprivation. Re-settlement experiences can also be traumatic including: being in an alien culture, a new education system, learning a new language, a lack of social support, ongoing life stressors and manoeuvring between home and school.

Intergenerational conflict between children, parents and grandparents due to the incompatibility between the home culture and the host culture is common in migrant and refugee background families. Asymmetric acculturation within families is a pattern in which children acquire the host country culture and language much faster than their parents and
grandparents, resulting in conflict and stress in migrant families (Matsuoka, 1990; Potocky-Tripodi, 2002).

The negative impact of racism and discrimination on the mental health of Asian, migrant and refugee youth is documented in a number of New Zealand studies (Ameratunga & Horner, 2011; Scragg, 2016; Wong et al., 2015). Belonging to a coherent and supportive family culture protects against the development of mental health problems (Hackett, Hackett & Taylor, 1991; Harker, 2001).

The experience of migration and settlement may impact directly and indirectly on children’s mental health. As children are migrants themselves, the migration stressors mentioned may apply to them but they may also have to cope with inadequate support from their parents owing to their parents’ preoccupation with their own migration stresses (Hicks et al., 1993). As well, children may have to support their parents, for example interpreting for them and explaining the new way of life, such as the school system. In the early settlement phase, migrant and refugee families may be confronted with financial hardship, unemployment and housing problems.

This resource will review common mental health disorders presenting to Child and Adolescent Mental Health Services (CAMHS) for Asian, migrant and refugee background children including: depression and anxiety; problem gambling; internet Game Addiction; drug and alcohol abuse; eating disorders; posttraumatic stress disorder; sexual identity issues and suicide risk. Cultural presentations of distress and cultural formulation and help-seeking behaviours will be discussed. Issues in regard to assessing migrant and refugee children include: intergenerational issues and using appropriate cultural assessment tools, cultural formulation tools and validated screening tools. Psychosocial interventions and their application will be demonstrated in case studies. Case scenarios demonstrate CALD culturally competent mental health practice. A section on resources provides information on referral agencies and culturally and linguistically appropriate psycho-education resources for health practitioners and consumers.

**System and service barriers**

Current experience and research conducted in New Zealand shows that Asian, and MELAA migrants and refugees are encountering difficulties in accessing New Zealand health services. In addition to the many wider systemic barriers, it has been found that language and cultural issues are the two most widely experienced barriers to service utilisation, adversely affecting equitable access to appropriate and quality care (Ho, Au, Bedford, & Cooper, 2002; Mehta, 2012; Ngai, Latimer, & Cheung, 2001; Walker, Wu, Soothi-O-Soth & Parr, 1998).
Asian and MELAA migrant populations are unfamiliar with New Zealand health and disability systems and many experience access barriers due to low English proficiency levels and a lack of knowledge of what services are available. Many migrants have difficulty understanding the roles and functions of different agencies and health professional roles within the NGO, primary, secondary care and social service sectors.

Asian and MELAA migrant populations are vulnerable. Research on service utilisation in New Zealand shows that Asian and MELAA populations are not accessing health services equitably with other populations and present late to services (Mehta, 2012; Perumal, 2011). The stigma associated with poor mental health is a significant factor in poor engagement with mental health services (Honey et al., 2014). There is a need for Mental Health and Addiction services to assist Asian/MEA service users and carers, (in particular non-English speaking service users) to navigate the network of services provided.

The following is a list of system or service barriers that can impact on the care of the child or a young person:

<table>
<thead>
<tr>
<th>System or service barriers can impact on the care of the child or young person</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Families unfamiliar with health services and how to access these services.</td>
</tr>
<tr>
<td>• Late presentation: families do not believe that the problem of the child/young person is a mental health issue or is not severe enough to seek help.</td>
</tr>
<tr>
<td>• Complex help-seeking behaviour for Asian/MEA families: access to other support instead of mainstream services (eg traditional healer, alternative therapies and spiritual and religious help) until the problem becomes too severe.</td>
</tr>
<tr>
<td>• Services are not perceived to be culturally sensitive.</td>
</tr>
<tr>
<td>• Language issues or concerns (parents/grandparents/caregivers).</td>
</tr>
<tr>
<td>• Perceived cost of service (eg may not know that the interpreting service is provided to the family at no cost).</td>
</tr>
<tr>
<td>• Family’s concern with the risk of stigma from the community, shame and embarrassment.</td>
</tr>
<tr>
<td>• Family does not allow/support the young person to access mainstream mental health care.</td>
</tr>
<tr>
<td>• Family does not accept the treatment or medications.</td>
</tr>
<tr>
<td>• Family does not engage with the therapist or disengages or does not comply with the treatment plan.</td>
</tr>
<tr>
<td>• Family concerns about the young person’s residency status.</td>
</tr>
<tr>
<td>• Family concerns about how accessing mental health services would impact on their future endeavours (eg education, employment and marital status of the young person).</td>
</tr>
<tr>
<td>• Family’s concern with the confidentiality of the service</td>
</tr>
<tr>
<td>• Family refuses to use professional interpreters and prefers to use their family members or the young person (client) to interpret (because of confidentiality issues).</td>
</tr>
</tbody>
</table>
System or service barriers can impact on the care of the child or young person

- No extended family support for the young person.
- No matching language interpreters available in some languages.

Cross-cultural skills

Cross-cultural skill refers to the ability to implement cultural awareness, sensitivity and knowledge in practice when working with CALD children, adolescents/ families, and the needs/issues they present with.

CALD cultural competence involves, being competent with:
- Addressing language barriers in clinical encounters (knowing how to use interpreters is essential). You can learn how work with interpreters by undertaking the following training which is available on line: CALD 4: Working with Interpreters (Waitemata DHB, eCALD® Services, 2014b).
- The Cultural-Awareness – Assessment – Negotiation Technique (Campinha-Bacote, 2011), which involves:
  - Being aware of the ethno-medical beliefs of the clients/family/ communities you serve.
  - Assessing the likelihood that a particular client/family may act on these beliefs during a particular mental health episode.
  - Negotiating between biomedical and ethno-medical belief systems.
  - Emphasising common goals (e.g. helping your child/young person to get better), while acknowledging differences.
  - If necessary or possible, incorporating non-harmful remedies in the treatment plan.
  - Not assuming that the family knows how to use the New Zealand health and disability system.
  - Referring to available culturally appropriate support services when required.
Communication
(Waitemata DHB, 2016b)

Many Asian, Middle Eastern and African gestures and greetings differ significantly from Western ones. To develop good rapport and show respect, here are some essentials for greetings and communication.

- Ask clients if they wish to be addressed using a **title and surname**, especially at the initial engagement (premature familiarity may be considered disrespectful (eg they may also address the health practitioner as Dr, Madam, Sir to show their respect).
- A **nod or slight bow** is customary when greeting East Asian families (Chinese, Korean, Japanese).
- **Older people should be greeted first** and last before leaving.
- **Avoid** prolonged or direct **eye contact**.
- **Over-familiar touch** is not appreciated.
- It is acceptable to **shake hands** with men.
- **Muslim women** may refrain from shaking hands with men.
- Preferably use **customary greetings** with women.
- **When in doubt, a smile and a slight bow of the head will always be appreciated.**
- Using hand **gestures** to summon someone is considered insulting.
- In most Asian cultures it is disrespectful to **touch another’s head** (except for medical examination).
- Many Asian/MEA clients will avoid **saying ‘no’** as it is considered impolite, so **‘yes’ may be ambiguous** and may indicate that the listener is paying attention; it does not necessarily indicate agreement.
- Showing **respect**, especially for elders, is appreciated (eg greeting the elders first, the practitioner being on time for appointments and greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance the relationship with the practitioner, and compliance.
- Health practitioners are usually highly regarded and clients may not ask **questions**, and may not answer in the negative as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions, especially when working through an interpreter.
- In most Asian cultures, ‘**Saving Face**’ is a strong principle and will be used over confrontation or questioning of those in authority. It is also important not to put a person in a position where they will be seen to ‘lose face’.
- Ask clients about their **expectations** of the service. **Some migrant families may expect medications, injections, practical help, and solutions rather than just a visit/consultation. For some migrants discussion alone may be seen as a waste of time.**
- Explain the **treatment process and timeframe**, immediately after diagnosis. **Some Asian clients are distressed by uncertainty and may choose to return to their home country for treatment if they are anxious.**
• Explain **confidentiality and privacy** especially when using interpreters. **Confidentiality becomes an issue in smaller communities or recently arrived groups.** Migrants may be reluctant to use an interpreter because he/she knows the interpreter and/or fears that details of the matter will be made public. At the beginning of the interview, reassure the client/family that you and the interpreter will respect his/her rights to confidentiality (unless there are serious safety concerns).

• Explain your **services and roles** clearly and provide **information in the client’s language.** Many migrants are **not familiar with New Zealand health and social services, legal rights and policies** eg the New Zealand definition of child neglect or family violence or the “no smacking” law, and they don’t know what services are free of charge eg **interpreting services** etc. Newcomers are not familiar with the routine and practical details of New Zealand health, mental health and disability services. It is most important to provide interpreters or support people to explain what is happening, to answer questions and to discuss any fears or worries with parents/grandparents.

• **Assess health literacy and English language proficiency.** **Do not assume someone who can respond with Yes or No answers understands English or comprehends medical terminology or information.** Also do not assume someone can read in English or in their own native language.

• Use **professional interpreters** where practical: **Avoid using a family member or a child to interpret.** NB Many Asian/MEA families refuse the use of interpreting services because they are not aware that it is free of charge, and are not aware of the roles, responsibilities and confidentiality required of interpreters. They may expect interpreters to provide additional support or transport for them. **It is important to explain the roles of interpreters to avoid misunderstanding.**

• **Give instructions** in a clear, logical sequence so that families understand eg providing **step-by-step instructions or using pictures/visual information.**

• **Being culturally competent is not about learning everything about a specific culture.** It is better to learn about the values of collective cultures and to learn some of the more common cultural beliefs and practices of the groups you serve rather than to try to learn a list of ‘do’s and don’t’s’ for working with CALD clients and families.

• **At the engagement stage, an awareness of alternate models of mental illness and efforts to find common ground can promote the development of rapport with CALD parents.** Enquiry regarding preferences for treatment modality may result in enhanced adherence. The Culture and Health-belief Assessment Tool (CHAT) (see the Assessing Migrant and Refugee Children and Adolescents section will assist you to understand diverse health beliefs and explanatory models of mental health and client/family preferences for care.
Collective cultures and traditional family values

An overview of collective cultures and traditional Asian, Middle Eastern and African (MEA) family values, health beliefs and practices is discussed in this section.

“Culture influences how culturally and linguistically diverse (CALD) communities from Asian and MEA backgrounds explain their health and wellbeing or respond to health and sickness, their behaviours, attitudes as well as their health seeking patterns.”

Families from Asian, Middle Eastern and African (MEA) backgrounds are very (extended) family oriented with a high priority placed on family, unity, dignity, respect, spirituality and humility. There are significant differences between collectivist and western individualist views about decision-making, family structure, gender roles and parenting.

Asian and MEA cultures, religions and languages have a significant impact on health beliefs and practices, influencing the way in which families explain their health and illness, and how they respond to and access health services. Cultural backgrounds also influence patient’s and family’s behaviour, family structure, decision-making, child rearing practices, caregivers’ roles, dress codes and dietary preferences.

Cultural groups have different ways of understanding illness and will attribute different causes to the origin and symptoms of mental health disorders/disabilities. How illness/disability is explained is strongly influenced by families’ cultural/religious backgrounds. To a large degree, these values also define the acceptable symptoms of the illness/disability as well as the behaviour, expression and role of the child and young person. Health beliefs are often complex and may change overtime with acculturation. For some CALD groups, after a long period of settlement in New Zealand, there may be little or no reliance on traditional practices. Some families will revert back to traditional health practices when they find that illness/disability is not responding well to Western medicine. CALD younger people who are New Zealand born or the 1.5 generation may not hold any traditional health beliefs and practices. To assess acculturation levels and to avoid stereotyping, individual assessment is essential.
Traditional Family Values

The following table provides a comparison of traditional collectivist family values with Western family values. **NB The information is generalized and is intended to highlight cultural differences and to enhance cultural understanding for health providers.**

<table>
<thead>
<tr>
<th>Asian</th>
<th>Western</th>
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<tbody>
<tr>
<td>• Family is the unit of society.</td>
<td>• Individual is the unit.</td>
</tr>
<tr>
<td>• Extended family.</td>
<td>• Nuclear family.</td>
</tr>
<tr>
<td>• Dependence and infirmity is more natural.</td>
<td>• Independence valued with illness needing to be eradicated.</td>
</tr>
<tr>
<td>• Decisions made by family, tribe or community as serves the collective interest best. Traditionally fathers and sons are seen as heads of household and decision makers.</td>
<td>• Decisions more often made by the individual or nuclear family.</td>
</tr>
<tr>
<td>• Traditionally (and currently still common) sons are valued over daughters.</td>
<td>• Generally similarly valued.</td>
</tr>
<tr>
<td>• Shame at ‘failures’.</td>
<td>• Guilt at ‘failures’.</td>
</tr>
<tr>
<td>• Honour, duty and filial love towards parents and family are very important.</td>
<td>• Individual rights.</td>
</tr>
<tr>
<td>• Child rearing is oriented towards accommodation, conformity, dependence, affection.</td>
<td>• Child rearing oriented towards individuation, intellectualisation, independence, and compartmentalisation.</td>
</tr>
<tr>
<td>• Religion plays an important role in symptom formation, attributions (God's will/karma) and management.</td>
<td>• Attribution of illness and recovery is seen to be self-determined, and psychological symptoms are attributed to weakness of personality, thinking patterns etc.</td>
</tr>
<tr>
<td>• Marriage partners often need approval from family, or are arranged by families.</td>
<td>• Marriage partners more often self-chosen.</td>
</tr>
<tr>
<td>• The health practitioner is seen as the authority and highly respected.</td>
<td>• Doubt in doctor-patient relationship.</td>
</tr>
<tr>
<td>• Informed consent is a family decision.</td>
<td>• Informed consent an individual decision.</td>
</tr>
<tr>
<td>• Seniors/elders highly respected.</td>
<td>• Elderly viewed much as any other age group.</td>
</tr>
<tr>
<td>• Honouring of ancestors</td>
<td>• Ancestors not usually a factor.</td>
</tr>
</tbody>
</table>

(Waitemata DHB, eCALD® Services, 2016f).
Family Structure

In this section, additional information about Asian/MEA traditional family structures, family-based decision-making, gender roles, parenting, intergenerational and other cultural expectations are provided. The suggested cultural approaches or considerations are included to expand health providers’ cultural understanding and to enhance engagement with families.

In New Zealand, Asian/MEA families who have extended family members often live together as a single-family unit, which includes grandparents, parents and children.

• The grandparent’s role in raising the children is a highly valued link to culture, religion and heritage.
• For traditional families with multiple sons, the parents or grandparents usually choose to live with the eldest son.
• Asian/MEA families value family ties and have a strong sense of obligation to and respect for seniors, loyalty and honour as well as duty to the family.
• It is a traditional belief that children have to give a lot of respect to parents and take care of parents when they get old.

Suggested approaches:
• Explore family dynamics and relationships.
• Find out who is the primary caregiver for the child.
• Explore the level of acculturation of the family members and their service expectations.
• Ask the client if he/she has family or community who can help the family in practical ways.

Decision-making

• The father or the husband is usually the decision-maker for bigger family issues. However, mothers are usually the main caregivers of the children and older persons.
• Some Chinese and Korean mothers may have difficulties with taking on the role of making decisions on serious health matters for their children, because their husbands are working in their homeland. While they may have to be the main decision-makers they may still need to discuss decisions with their husband first. This may lead to a lot of stress.
• Because of the value placed on interdependence and privacy in Asian/MEA cultures and the desire to “save face”, family issues including healthcare decisions, are frequently discussed within the immediate family before seeking outside help.

Suggested approaches:

• Establish the main decision-maker(s) for healthcare matters (including informed consent).
• For communication, convey information to both (father or the husband or the mother of the children or caregivers of the children or older persons) to avoid communication breakdowns.
• Find out if there is anyone overseas that needs to be contacted for healthcare decisions.

Gender roles

The roles of Asian/MEA men and women are distinct. Women manage the home by keeping all finances, family, and social issues in order. Women are more passive and men typically are the breadwinners and managers of issues requiring interaction with individuals in the community, eg health care. This type of behaviour implies that men have a dominant and authoritative role because they are the primary point of contact with society. However these roles are beginning to change among educated Asian/MEA families and among immigrants in progressive or permissive societies.

Suggested approaches:

• Ask who the primary care giver is for the child and who is responsible for decision making.

Parenting and grand-parenting

• In many Asian/MEA cultures, parents expect their children to be obedient, well-disciplined and to achieve high academic qualifications. Asian parents employ a “training” mode of upbringing, organizing children to attend different tutorials or interest groups, even after school and during holidays.
• Failure to meet expectations (eg academic) brings shame and “loss of face” to the child and the family.
Some parents are concerned about their children losing their native language ability and being unable to maintain traditional values. Children may be stressed by their parents’ traditional expectations and face conflict between traditional and western cultural values and peer group norms.

In most instances in Asian/MEA communities, the whole family is involved in the care of the children. Grandparents play an important role in rearing children.

Children often sleep with parents from the time of birth to early childhood. If the grandparents are part of care taking, the children may be as attached to the grandparents as to their parents. This may cause some attachment issues between the child and their parents.

Respect for elders is highly valued and children, including grandparents, older siblings, teachers, and family friends. The discipline of children is thought to come naturally. In some families, a child is responsible for many of the adult tasks, such as finance, legal forms, and interpretation/translation. Children from refugee backgrounds in particular may be responsible for adult tasks including the care of younger children.

China’s one child policy was introduced in 1979. This has resulted in the development of the 4-2-1 problem. This refers to the first generation of law-enforced only children becoming parents themselves. The adult child has two parents and four grandparents. Consequently, some Chinese parents and grandparents may over-indulge their only child or grandchild resulting in a child who may lack self-discipline and the ability to cooperate with others. The Chinese media refers to these traits as the “little emperor syndrome”. (Wikipedia, 2017). The impact of the one-child policy may result in some Chinese young couples having limited parenting skills.

Suggested approaches:

• Assess parents’ views about the importance they place on the child’s education and the child’s ability to cope with parental expectations of high achievement.

• Assess the child (if he/she can speak for himself/herself) on their own to determine stressors and issues (eg cultural identity issues, educational expectation, etc). Explain to the parents the importance of assessing the child on their own (if parents are not comfortable to have their child assessed without them).

• Ask the child for their choice for support: grandparents or parents – or better, both.

• Advise parents/grandparents against using their children as interpreters.

• Assess the effects on the child of having adult responsibilities.

• Explore the couple’s parenting skills and encourage parenting education or incredible years’ education. (If grandparents are involved as primary care givers, encourage them to attend parenting education programmes together with the parents).
Assessing Migrant and Refugee Children and Adolescents

Normality v Abnormality

Definitions about normality and abnormality vary widely from one culture to another, between age and gender groups, socioeconomic groups, and occupational groups. Notions of normality can also be contextual, for example behaviour that is not generally considered normal can be acceptable during festivities and celebrations, or cultural rituals. There are norms within cultures, where erratic, disturbed, threatening or self-destructive behaviour is seen as such and the individual may either be regarded as requiring treatment, meriting punishment, or to be avoided.

It is important for clinicians to contextualise the child and young person’s behaviour and mental state to their culture or group norms, not just those of the clinician. A clinician needs to exercise sensitivity and be aware of their own biases in order to achieve this.

The following compares Western individualistic society values with traditional collectivistic society values in regards to child rearing expectations and developmental expectations for children and young people. **NB: The information is generalized and is intended to highlight cultural differences and to enhance cultural understanding for health providers.**

<table>
<thead>
<tr>
<th>Western Individualist cultures</th>
<th>Traditional Collectivist Cultures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Rearing Expectations</strong></td>
<td></td>
</tr>
<tr>
<td>• Individual oriented.</td>
<td>• Family group oriented.</td>
</tr>
<tr>
<td>• Nuclear-blended family.</td>
<td>• Extended family.</td>
</tr>
<tr>
<td>• Primary relationship marital bond.</td>
<td>• Primary relationship- Parent-child bond</td>
</tr>
<tr>
<td>• Couple parenting.</td>
<td>• Filial piety.</td>
</tr>
<tr>
<td>• Emphasis on independence, individualism.</td>
<td>• Multiple parenting.</td>
</tr>
<tr>
<td>• Flattening of hierarchy (re intergenerational relationships).</td>
<td>• Emphasis on collective obligations interdependency collectivism.</td>
</tr>
<tr>
<td>• Status achieved by individuals efforts; youth self esteem.</td>
<td>• Clear unequal status parental relationship (paternalism).</td>
</tr>
<tr>
<td>• Flexible family member’s roles in regards to child rearing.</td>
<td>• Behavioural code – modesty, courteous.</td>
</tr>
<tr>
<td>• Democratic orientation.</td>
<td>• Status and relationships determined by age and role in family (Collective esteem).</td>
</tr>
<tr>
<td>• Opportunities for girls, blurred roles.</td>
<td>• Well defined family member’s roles: power/dominance- matriarchal/patriarchal.</td>
</tr>
<tr>
<td>• Achievement self-actualisation.</td>
<td>• Authoritarian orientation- compliance.</td>
</tr>
<tr>
<td>• Esteem – internal, self-reinforced.</td>
<td>• Favouritism towards male children.</td>
</tr>
<tr>
<td>• Competitive orientation, assertiveness.</td>
<td>• Security and stability- conservatism, resistance to change.</td>
</tr>
<tr>
<td>• Prefers spontaneity.</td>
<td>• Prioritise tangible things (structure, uncertainty)</td>
</tr>
<tr>
<td>Western Individualist cultures</td>
<td>Traditional Collectivist Cultures</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Avoidance, rituals and codes.</td>
<td>• Achievement: Academic/pragmatic orientation-collective actualisation.</td>
</tr>
<tr>
<td>• Honour/shame-esteem (face) dependent on external reinforcement.</td>
<td>• Cooperative orientation-conformity.</td>
</tr>
</tbody>
</table>

**Developmental Expectations of children and young people**

- Expectation that children will be independent and self-reliant.
- Essential skills are: being highly verbal, independent, emotionally controlled, self-reliant.
- Parents believe that a child has an inborn temperament, a set of personality traits that can be moulded by parenting and society.
- Babies are bundles of potential and a good parent is one who can uncover the latent abilities and talents in their child.
- Western parents are concerned about the self-esteem of their children.
- Parental awareness that children need good people skills.
- Successful children achieve a balance between self-maximisation and consideration of others.

- For example, Chinese culture is largely influenced by Confucian philosophy. This philosophy emphasizes respect for authority, devotion to parents, emotional restraint, and the importance of education.
- Chinese parenting practices are based on the concepts of chiao shun (to train) and guan (to govern and to love).
- Parents who want to train their children are very involved in their children’s lives; they show high levels of concern for them.
- For Chinese migrants, parenting becomes more difficult in the years following immigration. Physical discipline and other practices typical in China are less accepted in the west.

**Expectations for Chinese migrant children are high:**

- Adolescents are responsible for many family functions, including caring for siblings and family members, cleaning the home, and cooking meals.
- A child’s duty to the family is an accepted norm in Chinese households.
- Chinese parents are not necessarily driven to control their children; instead, they are expected to teach their children how to maintain harmony with others. For example, emotional expression is considered harmful to one’s health and relationships, and children are encouraged to avoid it.
- Such practices create the context for “saving face.” This value or behaviour is related to shame because it rewards conformity to society’s expectations for propriety and harmony.
Cultural considerations in assessment

Assessing children and adolescents is best done in a semi-structured way in order to establish rapport, engage the child and collect information. This relationship building approach is particularly important at the first interview when parents are usually included. Further interviews may need to be more structured, especially when assessing for diagnostic criteria, medico legal reports etc.

Rho and Rho (2009) suggest that:
• Having a parent or caregiver present may be useful in the initial interview.
• A qualified interpreter is important and the child should not be expected to act as an interpreter.
• A holistic approach is mandatory when working with children.
• Time should be taken to explain what a mental health worker is and what services are available.
• The use of questionnaires has been found to be useful but care needs to be taken when analysing the results of questionnaires as many scores have a Western bias. Allowances must be made for language and cultural differences.

Issues to be aware of during assessment and history taking
• There may be cultural differences in expectations of child development.
• An accurate age may be difficult to ascertain for children from refugee backgrounds.
• Trauma history: A thorough background history including exposure to traumatic events needs to be taken. This should include: the nature and extent of exposure to trauma, the age of the child at the time the maximum disruption occurred, and the degree to which the family was able to stay intact.
• Developmental delays in refugee children may result from chronic infections in childhood (for example cerebral malaria, from recurrent illness or from environmental deprivation due to war and famine.
• Hearing impairment may be due to past or current infection, exposure to explosive noise in war zones, or blows to the head. Hearing impairment in children may lead to developmental delays and learning difficulties. Hearing testing should be considered if indicated.
• Check for visual impairment if indicated.
• Physical health: The following should be considered (Ministry of Health, 2012):
  - Weight and height percentiles and a weight history.
  - History of malnutrition.
  - Anaemia is common in children from refugee backgrounds.
• Parents may not be aware of disability services and supports and how to access these.
• Keep in mind that some families may be reluctant to identify concerns, for fear of affecting their success in applying for permanent status.
• School readiness:
  - Ask whether a child has had prior access to schooling.
- Second language learners — children not proficient in English— may be equal in their physical readiness to learn, but behind in their language, general knowledge, communication and cognitive development.
- If a child has an additional developmental problem, it is important to link the child to programmes that improve school readiness, such as structured preschool programmes, as well as other developmental services.

- Sexual health history:
  - Children and adolescents (female and male) from refugee backgrounds may have been sexually assaulted during refugee flight and refugee camp experiences. Addressing sexual assault needs to be managed with extreme sensitivity. This matter should usually be discussed without other family members present.
  - Address developmentally appropriate sexual activity including safer sex issues.
  - Be aware of underage marriage.
  - Culture and health-belief assessment tool (CHAT).

The CHAT tool can be used in a wide variety of clinical settings, with patients from any cultural background. The questions listed in CHAT are intended to stimulate discussion, giving the clinician a greater understanding of the client’s health-belief model, health practices and expectations for treatment (Adapted from Kleinman et al., 1978).

- What do you think caused your illness?
- Why do you think your illness started when it did?
- What does your illness do to you? How does your illness work?
- How bad (severe) do you think your illness is? Do you think it will last a long time, or will it be better soon, in your opinion?
- What do you fear most about your illness?
- What are the chief problems that your illness has caused for you?
- When you have a problem, to whom do you turn for help?
- For your future care, who would you like to be involved?
- What have you done to treat your illness?
- What kind of treatment do you think you should receive?
- What are the most important results that you hope to receive from treatment?
- Is there anything that might conflict with your treatment regimen?
- Are you feeling uncomfortable or uncertain about what we have decided?

**CALD assessment tool for children and adolescents**

The **CALD Assessment Tool for Children and Adolescents** is useful for exploring family’s cultural and ethnic identity and their explanatory models of health and illness. The information on A and B in this section is for use with the tool.
[A] Cultural and ethnic identity

- **Parent’s expectation of the child’s development and behavior.**
  Conducting culturally sensitive interviews with a young child can be challenging, particularly if the parents do not understand why they have been referred. They may be hesitant to disclose details about the child’s behaviour at home if they do not know why they are being asked for the information (Rho & Rho, 2009). It is important to understand the parent’s expectation of the child’s development and behaviour, and whether they see the issue as problematic in their own culture.

- **Child’s insight to what behaviour is acceptable at home.**
  Using culturally sensitive assessment toys and gaining insight into what behaviour is regarded as acceptable at home, can help the clinician to understand the reason for referral. Children may be encouraged to be assertive and outspoken at school, but in the collectivist culture they come from, this may not be acceptable.

- **Parenting style.**
  Corporal punishment is commonly used in traditional societies (Rho & Rho, 2009). When children get referred to clinicians by child protection services, it is important to treat the parents in a culturally sensitive, non-shaming way and to explain that in New Zealand alternative forms of punishment are preferred and that corporal punishment is illegal. Normalising the behaviour in an understanding way and providing guidance on alternative forms of punishment such as time-out, is very useful to parents. Educating parents through language appropriate parenting programmes such as the Incredible Years Programme (IYP) will assist with developing parenting skills in the New Zealand context.

- **Acculturation and migration experiences.**
  Assessing migrant Asian/MEA children who are in the process of acculturating can be challenging. These children are navigating their way through developmental milestones in a new culture, language and society. Because developmental processes can be disrupted during migration due to acculturation (as well as pre-migration experiences for children from refugee backgrounds), it can be difficult to assess developmental stages in the context of cultural norms.

  Age at the time of migration is an important factor when assessing cultural differences in expression of psychological symptoms (including somatisation). The influence of acculturation is more obvious in those adolescents who migrated at a young age (Chan & Parker, 2004).
• **Suggested assessment approaches.**

Rho and Rho (2009) suggest taking the following cultural factors into account when conducting assessments:

**Children:**
- When assessing children’s development, it is important to bear in mind that childhood milestones can be culturally based (e.g., expectations for toileting skills can vary from 4 months to 4 years, ages at which children walk or talk can depend on child-rearing practices, etc.).
- In many cultures, children are expected to be ‘seen and not heard’ and may not communicate assertively with adults, whilst in other cultures children are the centre of attention and are accorded many privileges until a certain age. Expressiveness, both vocal and physical may differ significantly across cultures.

**Adolescents**
- It is important to assess whether identity has been established. Emerging independence in adolescence, recognised in Western cultures, may not be relevant to other cultures. In collectivist cultures where modesty, respect, courtesy and loyalty are valued, independence is usually not valued. Conflict may occur within families, but also within the adolescent who is caught between two cultures and is trying to define themselves, their values and their beliefs.
- Sexuality issues, interethnic relationships and taboo subjects like homosexuality will need to be explored in a very sensitive way.
- If delinquency issues are involved, referral to school liaison teams may be needed. However, parents may need to be educated about the process and this will require careful cultural consideration.
- Due to peer pressure to join a new culture, and adjustment difficulties, drug and alcohol abuse may be a problem. Psychoeducation on addiction issues may not be accessible to parents due to language barriers.

**Engaging with family**

Many CALD children are likely to come from families that are family-centered, with extended members, rather than from nuclear families. It is important to ask who the main caregiver and/or decision maker is and to involve them in the process of assessment, intervention and treatment. Individually oriented care is often not appropriate for clients where families make decisions about treatment and care. In collectivist cultures, children and young people’s independence and
empowerment are not valued in the same way, or may be at odds with families' wishes. Explore the role of religion and the church/mosque/temple for the family.

**Potential problems may arise if:**
- Individuals and not families are consulted.
- There is insufficient understanding about how family structures differ across cultures, and who is included in family boundaries.
- Key family members are not included in consultations and treatment plans and so do not support, or may even prohibit proposed interventions.
- Family members attending the consultations may not fully understand the plans or reasons for them and are unable to convey these to the head of the family. Sometimes the misunderstanding is because of language or lack of familiarity with the medical terminology, at other times it may be due to confusion around multiple services and clinicians. Identify the key caregiver in the family and include them in the consultations. This person is not always a parent, and may also not be the key decision maker. If they are not involved they may not understand or be invested in intervention and treatment plans.

**Implications for practice**
- Involving parents or family in the assessment of a CALD child is helpful in establishing acculturation rates for the child and parents. Acculturation, and differences in levels between parent and child, may be at the root of a problem, but may not be obvious in the presenting issue.

**[B] Explanatory models of illness**

Children also have their own explanations for illness, so it is important to explore the child (as well as the family's) understanding of the problem, and their expectations and beliefs about outcome.

**Issues relevant to refugee children and adolescents**

Children and young people from refugee backgrounds, despite their resilience, may experience mental health difficulties that only manifest some time after settling. In particular, PTSD may present 2-3 years after migration when the child/adolescent has developed trust in their surroundings (Ministry of Health, 2012).

Young refugees are frequently subjected to multiple traumatic events before and during their migration journey. These may include the loss of parents and siblings, extended family, friends, security and homes, as well as witnessing or experiencing extreme trauma. Ongoing stressors within the host country may exacerbate previous stress. Children are also vulnerable to the intergenerational transmission of trauma. The Cambodian and Vietnamese
refugees (and some Laotians) who resettled in New Zealand in the 1970s and 1980s were a highly traumatised group and they have tended not to seek mental health intervention for a variety of reasons. So a migration history for Southeast Asian children and adolescents who present in New Zealand healthcare would be important. Some of these children may be carrying the burdens of the unresolved issues of their parents and grandparents.

An awareness of relevant risk and protective factors is important. Commonly reported issues include PTSD, grief, depression, anxiety, sleep disorders, somatic complaints, conduct disorder, social withdrawal, attention problems, generalised fear, over-dependency, restlessness and irritability (Ministry of Health, 2012). In New Zealand, substance abuse is a problem amongst refugee adolescents, and PTSD, depression and anxiety disorders are recognised as co-morbid features. Despite treatment, reoccurrence is common.

Refugee children are often reticent to discuss past traumas and choose to focus on the future. This should not be discouraged because a future-orientated view has been associated with lower rates of depression in refugees (Beiser & Hyman, 1997). Working with refugees is covered in more detail in the supplementary resource ‘Working with Middle Eastern and African clients in mental health’ (Waitemata DHB eCALD® services, 2013).

The CALD assessment tool for children and adolescents, which follows serves to remind the practitioner to investigate the client’s migration/refugee experience and ethno cultural background and to orient care accordingly.

**CALD assessment tool for children and adolescents**
(Waitemata DHB, eCALD® Services, 2010).

The following questions are useful for exploring family cultural and ethnic identify and explanatory models of illness.
A. Questions for establishing cultural and ethnic identity.

- Tell me about how you (and your family) came to New Zealand? Do you know why you left your home country? With whom did you migrate? Did you leave any special friends or family members behind?
- How is your life in New Zealand? Tell me about making friends here? What differences do you notice between what happens in your house and what happens in your friend’s houses? Do you still do lots of things that you would have done in your home country? (like eating special foods or having special ceremonies).

A.1. Questions to explore ethically shaped developmental experiences:

A.1.1 Childhood experiences.

- What are some of the things you remember doing at home (before coming to New Zealand)?
- Did you go to school before coming here? (depending on age, explore how many years, primary/secondary).
- Tell me about any special rituals you have gone through which you can remember (inquire about special rituals or rites of passage).
- How are things at home for you? Are Mum and Dad and your brothers and sisters still doing things like they would have done before you came to New Zealand? (enquire about ethnically prescribed family roles).
- Tell me about the clothes you like to wear now? Has anything changed?

A.1.2 Language.

- What language do you speak at home? Do you speak the same language with your mum and dad and with your sisters and brothers? What about with your friends?
- Did you learn any foreign languages (that is other than the one you speak at home) in your home country?
- What language did the teachers speak at your school back home?
- What language do you prefer to use when you speak to your friends and relatives? Do you prefer your own language or English? Why?

A.1.3.

- What things do you think boys and girls do differently? What do you
### Gender issues related to culture.

Think about these differences:
- Who in the family should make the important decisions? Who makes the important decisions in your family?
- Are there things that only certain people in your family are allowed to do? How do you feel about that?

### A.1.4. Age.

- Who is the oldest person in your house? Do they make all the rules in your house? Did they always make the rules, even before you moved here? Does everyone have to listen to them, even mum and dad? How do you feel about that?
- What happens if you don't do what they tell you to do?
- How was it before you came here?

### A.1.5. Religious and spiritual beliefs.

- Tell me about your religion? Do you go to a church/mosque etc. (if yes continue, if no go to A1.6).
- How often do you go to the church/mosque/temple?
- What is it like going to the mosque/church/temple?
- Did you go to a mosque/church/temple before you came to this country? If yes, would you like to go again?
- Do you eat any special foods? Is there anything you are not allowed to eat?

### A.1.6. Socio-economic class and education.

- Was your family wealthy before you came here?
- What do you think it would be like if you were back in your country now?
- How would you describe things now?

### A.1.7. Acculturation process can be assessed by asking.

- What do you think it means to be a real kiwi?
- What helps new immigrants fit in, in New Zealand?
- How has it been for you fitting in?

### B. Questions to Explore cultural explanatory model of illness.

- Tell me about some of the things you are finding difficult?
- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your illness does to you?
- What bothers you the most about how you feel?
- Is there something about your illness that scares you?
## CALD Assessment Tool for Children and Adolescents
(adapted from Benson & Thistlethwaite, 2009; Pal, 2008).

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What kind of treatment / help do you think you should receive?</td>
</tr>
<tr>
<td>• Do you know how your illness would have been treated if you were still in your home country?</td>
</tr>
</tbody>
</table>

## C. Cultural factors related to psychosocial environment and levels of functioning.

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do you go to school? Do you learn similar things to what you learnt at school before coming here?</td>
</tr>
<tr>
<td>• How is school for you?</td>
</tr>
<tr>
<td>• What do you think about the children at school?</td>
</tr>
<tr>
<td>• How do you find the teachers?</td>
</tr>
<tr>
<td>• Tell me about your friends? How do you feel about play dates and sleepovers? What do your parents think about it?</td>
</tr>
<tr>
<td>• Tell me about the friends you left behind in your country? Do you ever contact them?</td>
</tr>
<tr>
<td>• Do you play any sports? Or do you have other special activities after school? What do you do after school?</td>
</tr>
<tr>
<td>• How do you find speaking English at school?</td>
</tr>
<tr>
<td>• Do you ever meet with people that come from the same country/culture as you do? What do you think about them?</td>
</tr>
</tbody>
</table>
Intergenerational conflict

Intergenerational conflict, that is, between parents and children, between parents and grandparents, and between children and grandparents, is very common in Asian, Middle Eastern and African families (Potocky-Tripodi, 2002). Intergenerational conflict between parents and grandparents is explored in the section on ‘Intergenerational and interethnic family relationship issues’. This section will explore the conflict between parents and children, and children and grandparents.

Intergenerational conflict is due largely to different acculturation rates between the generations, meaning that the different generations adopt the norms of New Zealand society at different rates, resulting in different expectations of behaviour from parents and grandparents (Matsuoka, 1990).

Many Asian/MEA families maintain close ties with family members in countries of origin and therefore the concept of family is transnational. Physically distant family members have a significant influence on parenting and child rearing practices, and on decisions about health care and family dynamics.

The following framework is useful for providing a general understanding of the range of intergenerational conflicts faced by most Asian migrant families.

Assessing intergenerational conflicts tool

<table>
<thead>
<tr>
<th>Adolescents</th>
<th>Parents</th>
<th>Grandparents (In NZ and in home countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender Roles</strong></td>
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<tr>
<td>Expectations regarding education, work, household tasks, dating, discriminating rules</td>
<td>Decision-making, careers, roles for children, who cares for grandparents?</td>
<td>Expectations of education and careers for children; who will care for them as they age?</td>
</tr>
<tr>
<td><strong>Respect</strong></td>
<td></td>
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<tr>
<td>How much assertiveness is tolerated by parents? How do I respect parents and grandparents and still disagree with them? Am I viewed as aggressive by other members of my</td>
<td>How do I encourage assertiveness without losing the respect of my children? How do I be assertive in my career and with New Zealanders? How do I deal with New Zealanders who do</td>
<td>How much assertiveness from children and grandchildren should be tolerated? How do I maintain the respect of both my children in New Zealand and in my country of origin?</td>
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<tr>
<td>migrant community?</td>
<td>not show respect?</td>
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<tr>
<td><strong>Power Shifts</strong></td>
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<tr>
<td>How much influence do aunts and uncles have over me? What role does tradition and religion have in guiding my future? How much say do I have in my own future?</td>
<td>How much influence do my parents have over me? What is my role with siblings? How do I empower my children without losing them to “kiwi” culture?</td>
<td>How can I set different expectations for my children in New Zealand and in my country of origin? What is my role with the grandchildren? What kind of prestige comes from having a family in New Zealand?</td>
</tr>
<tr>
<td><strong>Life Cycle</strong></td>
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<tr>
<td>How does identity change across the life cycle? How do I incorporate the best of both worlds as I mature?</td>
<td>How does identity change over the life cycle for me and my children? Have I prepared my children to be ethnic New Zealanders? How do I prove to my parents that leaving my country of origin was a good idea? How do I prove that I will remember my culture and heritage? What role should I play in choosing a spouse for my children? What is my role in helping them find a career? How do I maintain discipline?</td>
<td>How does identity change over the life-cycle? How will aging children and grandchildren maintain their identity? Have I prepared and taught them enough?</td>
</tr>
<tr>
<td><strong>Triangulation</strong></td>
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<tr>
<td>In what way am I caught in the middle between my parents and grandparents and their conflicts?</td>
<td>In what way am I in the middle between my children and grandparents? What must I do to maintain their relationship?</td>
<td>In what way am I caught in the middle between my children and grandchildren and their conflicts?</td>
</tr>
<tr>
<td><strong>Westernisation</strong></td>
<td></td>
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<tr>
<td>What does it mean to be a “Kiwi”? How much New Zealand identity do I want to incorporate into my identity? How do I avoid aspects of New Zealand culture while living in the culture?</td>
<td>How much westernisation is unavoidable among children? How do I avoid negative western values (eg individualist values) while living in New Zealand?</td>
<td>How much western culture should be adopted by family living in my country of origin?</td>
</tr>
</tbody>
</table>
Intergenerational conflict related to children and adolescents

The major source of intergenerational conflict is differential acculturation. This is particularly true in relation to migrant children and adolescents. Immigrant and refugee background children learn English and New Zealand culture before their parents and grandparents. Children are often given adult responsibilities and placed in the role of interpreter/translator in relation to dealing with schools; health care and social support services etc. Role reversal may lead to a lack of respect by children of their parents and grandparents. Children will follow the norms of behaviours of their peers which may be upsetting to parents and grandparents.

Parents may be so overwhelmed by the stressors of the migration process that they are unable to provide emotional support to their children and may turn to their children for emotional support themselves (Athey & Ahern, 1991).

• Intergenerational conflict and gender role expectations
  Another source of conflict between children and parents/grandparents may be gender roles. Parents may have gender role expectations for their children that are incompatible with behaviours the children need to function effectively in New Zealand society. For example, parents may expect girls to be quiet, obedient and subservient, whereas assertiveness, initiative, independence and competitiveness are needed in order to achieve in school (Potocky-Tripodi, 2002). When faced with these contradictions, girls may rebel at home. Parents may place more restrictions on the behaviours of daughters than sons, leading to resentment by girls, particularly in comparing themselves to their peers.

• Maintaining parental discipline
  Parental discipline of children is often problematic. The long hours that parents spend at work in order to support their family may lead to children being without parental supervision for long periods (Matsuoka, 1990). Intergenerational role reversals may result in a loss of parental authority over children. Children soon learn that some kinds of discipline eg corporal punishment are considered child abuse in New Zealand and some use this knowledge to threaten to report their parents to the police. Parents should be encouraged to attend parenting programmes, for example Incredible Years Training to learn new parenting practices.

• Intergenerational conflict with grandparents
  Conflicts are likely to arise between grandparents and grandchildren, and also between grandparents and parents, because grandparents may disapprove of the parent’s new child rearing practices (Carlin, 1990). For example, conflicts about what language should be used in the home are common. Grandparent’s lack of English language ability makes
them highly dependent on younger family members, adding to the increased likelihood of conflict.

Asian cultures place a high value on filial piety, which refers to children treating parents with a high degree and respect and taking care of them in their old age (Chang & Moon, 1997). In Asian cultures, older family members are wise advisors. However, this status is lost, since their life experience is seen as irrelevant to living in New Zealand, leading to a lack of respect by younger people.

**Life Cycle Issues**

A major developmental task of adolescence is identity formation. CALD migrant adolescents frequently experience substantial conflict regarding their ethnic identity. For Asian/MEA migrant children, the task of forging an ethnic identity is compounded by competing demands from two cultures (Potocky-Tripodi, 2002). Whereas at school and with their peers, children are rewarded for westernising as quickly as possible, at home new habits and behaviours are discouraged.

Adolescent’s reactions to ethnic identity conflict may vary. Some may reject one culture or the other, effectively removing themselves from interaction with members of that culture. Some may develop a heightened sense of ethnic/religious pride, often in reaction to experiencing racism and discrimination. Others will experience alternating periods of identifying with one or the other culture and some will selectively choose elements from both cultures to fit their circumstances (Gopaul-McNicol, 1993). This is considered to be the ideal outcome (Potocky-Tripodi, 2002).

Asian, migrant and refugee parents have expectations for high academic achievement for their children (Carlin, 1990). Some children faced with migration stressors, refugee resettlement, the developmental tasks of adolescence, ethnic identity conflicts and pressure to succeed are at risk of developing mental health problems arising from multiple stressors.

Ann An, 19, moved to New Zealand as a child with her parents from China. “If I said I felt fully Chinese I would be lying, because I see myself more as a New Zealander”. Parents want children to carry on their ethnic values and identity. Strict parenting styles may be perceived as being authoritarian. Youth identify more with their peers in a new country than their family. This may lead to complicated relationships and negotiations with their parents. Children balance parent’s/grandparent’s expectations; and want to be like Kiwi friends. Migrant parents fear losing children to the new culture but want children to have a better life.

*NZ Herald (May 18th 2016).*
Case Study 1: Psychosocial and familial stress following migration

“The child who sees ghosts every night: Manifestations of psychosocial and familial stress following immigration (Fang, Lee & Huang, 2013). This case study demonstrates how the sociocultural factors and cumulative stressors associated with migration experiences can significantly impact on each family member, as well as the family unit as a whole. This case study can be requested free of charge from your DHB library service or academic provider.

Brief background of the case
Joey and his parents are first-generation immigrants from a suburban area of Southern China. Arriving in the United States at age 6, Joey had only 1 year of preschool education in China and has received most of his formal education in the United States. Joey has acculturated to western culture, while his parents, who moved in their 30s, speak little English and strongly adhere to their traditional cultural values and practices.

The presenting issue in this case, namely ghost-seeing, was understood by the attending clinician from a culturally relevant perspective. Rather than focusing on the boy (Joey) seeing ghosts as the treatment target, the therapist uses Joey’s experiences as a vehicle to assess and identify the possible underlying mechanisms for his symptoms.

The case demonstrates successful strategies used by the therapist to engage with Joey and his parents:

• The therapist while empathising with the struggles that Joey and his parents had undergone as migrants, honoured each family member’s strengths and commitment to rebuild family cohesion, and focused on assisting the parents to improve their family relationships as well as their work and housing situation.
• The therapist applies cultural assessment skills in making a differential diagnosis.
• The therapist laid out a tentative case formulation and treatment plan during the initial visits, allowing Joey and his parents to have a clearer sense of treatment goals and plans and consequently result in a shared treatment approach.
• With the treatment plan focusing on the family as a whole, both Joey and his parents were supported while working toward positive family changes.

The case formulation includes exploring the following:

• What should the diagnostic formulation be for Joey?
• What other diagnoses could be considered in making a differential diagnosis?
• What culture-specific information will be needed to make an accurate psycho-social assessment of this case?
• What do you know about the cultural explanations for Joey’s illness?
• What factors in this case assisted Joey’s parent’s effective help-seeking behaviour and therapeutic engagement?
• What cultural elements are involved in Joey and his parent’s engagement with mental health services and in the therapist client/family relationship?

Validated screening tools

• The mental health assessment and screening tools used in New Zealand have not been tested for their reliability/validity with Asian/MEA clients. Hence, clinicians need to use additional information to support clinical assessments including cultural information and information from family members (Waitemata DHB, Asian Mental Health Working Group, 2011).

Ethnic differences in DSM-classifications

Because cross-culturally validated screening instruments are hardly ever used for ethnic populations, there is a potential biasing effect in diagnostic procedures when working with Asian, Middle Eastern and African children and adolescents. International studies have found that non-ethnic minority youth more often receive specific psychiatric disorders and co-morbid diagnoses on Axis I, while ethnic minority children more often received V-codes only, indicating that there is insufficient information to determine a psychiatric disorder (de Haan et al., 2014). The findings that it is harder to recognise psychiatric disorders when ethnic minority clients are diagnosed may imply that refugee and migrant children and adolescents are not adequately treated for their disorders in Child and Adolescent Mental Health Services.

A number of studies show that psychiatric disorders are under-diagnosed with ethnic minority youth. A substantial part of this under-diagnosing can be attributed to the influence of ethnic stereotyping when professionals have to judge children from ethnic minority groups (Reijneveld et al., 2005; Zwirs et al., 2006). Other studies have indicated that diagnoses generated through the use of cross-culturally validated diagnostic instruments, conducted in accordance with standard rules for information gathering, are more valid than are clinician-generated diagnoses (Aklin & Turner, 2006; Basco et al., 2000). In addition, diagnostic accuracy (an agreement between diagnoses generated by the clinician or by validated instruments) predicts better therapy engagement and a decreased likelihood of therapy dropout (Jensen-Doss & Weisz, 2008).

de Haan et al, (2014) and others have found that when ethnic minority children are referred to CAMHS, mental health practitioners may identify their disorders differently from majority culture clients. Different ethnic groups express mental health problems in different ways to majority culture groups. Additionally, for ethnic minority clients the language used for expressing distress may differ from that of the host country, which hinders the diagnostic process (Nikapota & Rutter, 2008). As well, Asian and other ethnic minority parents may be
less willing, or less capable of sharing information on their child’s development (Pels & Nijsten, 2003). Sharing information about the child’s early years is important, because it is hard to make correct diagnoses, for example with ADHD or autism, without it. In Dutch studies, minority children who present to CAMHS are mainly treated for relational problems and not for psychiatric disorders indicating that there is an ethnic bias in the diagnostic process (de Haan et al., 2014).

Currently, diagnostic instruments, if used at all, are often not specific and sensitive enough to diagnose correctly with non-native groups (de Haan, 2014). For assessing diagnoses with (non-native) children and adolescents, it would be best if this was done on the basis of deciding if diagnostic criteria are met, modelled on the gold standard for each disorder and alongside other clinical and cultural assessment tools. This can, for instance, be done with the Schedule for Affective Disorders and Schizophrenia for School-age Children (K-SADS), which is a semi-structured diagnostic interview designed to assess current and past episodes of psychopathology in children and adolescents according to DSM-V criteria (Kaufman, Birmaher, Brent, Rao, & Ryan, 1996; Puig-Antich & Chamber, 1978). The K-SADS is administered by interviewing the parent(s) and the child and, finally, achieving summary ratings that include all sources of information (parent, child, school, chart and other).

The DSM-V offers an adaptive interview technique (the Cultural Formulation of Diagnosis) (APA, 2013a; APA, 2016; Kirmayer et al., 2008) to compensate for the cultural insensitivity of diagnostic instruments. Cultural interviews provide additional information on the client’s life context and perceptual meanings and can ultimately facilitate comprehensive care (Marsella & Kaplan, 2002). Assessing a client’s cultural and religious perspectives; health beliefs and practices and perceptions of health and illness is important to make a comprehensive, culturally sensitive assessment (Lonner & Ibrahim, 2002).

The DSM-V specifies that in order to make a diagnosis of a mental disorder, the behaviour in question must not merely represent a culturally expectable and sanctioned response to a particular event, even though it may seem odd in the light of the examiner’s own cultural standards. The DSM-V also recognises that abnormal behaviours may take different forms in different cultures and that some abnormal behaviour patterns are culturally specific (see section on Cultural Presentations of Distress).

The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-V) includes an Outline for Cultural Formulation (CF) that identifies cultural information that can be used to modify diagnosis, clinical assessment and treatment plan. Cultural Formulation can be a useful tool for interdisciplinary collaboration and knowledge transfer by providing a framework to systematically introduce different disciplinary perspectives and levels of description that transcend the narrow frame of disorder-centred psychiatric diagnosis, assessment and care (Dinh et al., 2012).
The "Outline for Cultural Formulation" in DSM-V systematically calls attention to five distinct aspects of the cultural context of illness and their relevance to diagnosis and care. The clinician is encouraged to:

1. Inquire about patients' cultural identity to determine their ethnic or cultural reference group, language abilities, language use, and language preference.
2. Explore possible cultural explanations of the illness, including patients' idioms of distress, the meaning and perceived severity of their symptoms in relation to the norms of the patients' cultural reference group, and their current preferences for, as well as past experiences with, professional and popular sources of care.
3. Consider cultural factors related to the psychosocial environment and levels of functioning. This assessment includes culturally relevant interpretations of social stressors, available support, and levels of functioning, as well as patients' disability.
4. Critically examine cultural elements in the patient-clinician relationship to determine differences in culture and social status between them and how those differences affect the clinical encounter, ranging from communication to rapport and disclosure.
5. Render an overall cultural assessment for diagnosis and care, meaning that the clinician synthesises all of the information to determine a course of care.

Cultural formulation (DSM V)

Mental health service provision for culturally diverse populations requires assessment and treatment planning that is sensitive to the client and their family’s ethno-cultural background and social context (APA, 2013a; Hilt & Nussbaum, 2016; Kirmayer et al., 2008). To assist clinicians in identifying clinically relevant aspects of a clients’ cultural background, the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-V) includes an Outline for Cultural Formulation (CF) that identifies cultural information that can be used to modify diagnosis, clinical assessment and treatment plans (APA, 2013a). The ICD -10 may also be a useful reference (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Tasman et al., 2014). The ICD 10 adaptations include Asian and Latin American developments in the classification of mental health disorders which have importance because they represent attempts to adapt DSM V international standards to diverse cultural realities and needs.

Evaluations studies suggest that the CF can be a useful tool for interdisciplinary collaboration and knowledge transfer by providing a framework to systematically introduce different disciplinary perspectives and levels of description that transcend the narrow frame of disorder centred psychiatric diagnosis, assessment and care (Dinh et al., 2012; Kirmayer et al., 2008).
### CULTURAL FORMULATION INTERVIEW (CFI)—INFORMANT VERSION

**(GUIDE TO INTERVIEWER)**

The following questions aim to clarify key aspects of the presenting clinical problem from the informant’s point of view. This includes the problem’s meaning, potential sources of help, and expectations for services.

**INTRODUCTION FOR THE INFORMANT:**

I would like to understand the problems that bring your family member/friend here so that I can help you and him/her more effectively. I want to know about your experience and ideas. I will ask some questions about what is going on and how you and your family member/friend are dealing with it. There are no right or wrong answers.

#### CULTURAL DEFINITION OF THE PROBLEM

(Explanatory Model, Level of functioning)

| Elicit the individual’s view of core problems and key concerns. | 1. What brings you here today? |
| Focus on the individual’s own way of understanding the problem. | IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE: |
| Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (eg, “your conflict with your son”). | People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem? |
| Ask how an individual frames the problem for members of the social network. | 2. Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them? |
| Focus on the aspects of the problem that matter most to the individual. | 3. What troubles you most about your problem? |

#### CULTURAL PERCEPTIONS OF CAUSE, CONTEXT, AND SUPPORT

**CAUSES**
### Cultural Formulation Interview (CFI)—Informant Version Cultural Formulation Interview
(CFI)—Informant Version (APA, 2013a)

| (Explanatory Model, Social Network, Older Adults) | Why do you think this is happening to you? What do you think are the causes of your [PROBLEM]?
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<td>This question indicates the meaning of the condition for the individual, which may be relevant for clinical care.</td>
<td>PROMPT FURTHER IF REQUIRED: Some people may explain their problem as the result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes.</td>
</tr>
</tbody>
</table>
| Note that individuals may identify multiple causes, depending on the facet of the problem they are considering. | 5. What do others in your family, your friends, or others in your community think is causing your [PROBLEM]?
| Focus on the views of members of the individual’s social network. These may be diverse and vary from the individual’s. | |

### STRESSORS AND SUPPORTS
(Social Network, Caregivers, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Cultural Identity, Older Adults, Coping and Help Seeking)

<table>
<thead>
<tr>
<th>Elicit information on the individual’s life context, focusing on resources, social supports, and resilience. May also probe other supports (eg, from co-workers, from participation in religion or spirituality).</th>
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<tbody>
<tr>
<td>Focus on stressful aspects of the individual’s environment. Can also probe, eg relationship problems, difficulties at work or school, or discrimination.</td>
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<tr>
<td>6. Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others?</td>
</tr>
<tr>
<td>7. Are there any kinds of stresses that make your [PROBLEM] worse, such as difficulties with money, or family problems?</td>
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### ROLE OF CULTURAL IDENTITY
(Cultural Identity, Psychosocial Stressors, Religion and Spirituality, Immigrants and Refugees, Older Adults, Children and Adolescents)

<p>| Sometimes, aspects of people’s background or identity can make their [PROBLEM] better or worse. By background or identity, I mean, for example, the communities you belong to, the languages you speak, where you or your family are from, your race or ethnic |
| --- | --- |</p>
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<th>Cultural Formulation Interview (CFI)—Informant Version Cultural Formulation Interview (CFI)—Informant Version (APA, 2013a)</th>
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<tr>
<td><strong>Ask the individual to reflect on the most salient elements of his or her cultural identity. Use this information to tailor questions 9–10 as needed.</strong></td>
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<tr>
<td>background, your gender or sexual orientation, or your faith or religion.</td>
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</tbody>
</table>
| **Elicit aspects of identity that make the problem better or worse.**  
*Probe as needed (e.g., clinical worsening as a result of discrimination due to migration status, race/ethnicity, or sexual orientation).* |
| 8. For you, what are the most important aspects of your background or identity? |
| **Probe as needed (e.g., migration-related problems; conflict across generations or due to gender roles).** |
| 9. Are there any aspects of your background or identity that make a difference to your [PROBLEM]?
| 10. Are there any aspects of your background or identity that are causing other concerns or difficulties for you? |
| **CULTURAL FACTORS AFFECTING SELF-COPING AND PAST HELP-SEEKING** |
| **SELF-COPING**  
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors) |
| **Clarify self-coping for the problem.** |
| 11. Sometimes people have various ways of dealing with problems like [PROBLEM]. What have you done on your own to cope with your [PROBLEM]?
| **PAST HELP-SEEKING**  
(Coping and Help Seeking, Religion and Spirituality, Older Adults, Caregivers, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship) |
| **Elicit various sources of help (e.g., medical care, mental health treatment, support groups, work-based counselling, folk healing, religious or spiritual counselling, other forms of traditional or alternative healing).** |
| 12. Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?
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<th>Cultural Formulation Interview (CFI)—Informant Version Cultural Formulation Interview (CFI)—Informant Version (APA, 2013a)</th>
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<tbody>
<tr>
<td><strong>Probe as needed (eg, “What other sources of help have you used?”).</strong></td>
</tr>
<tr>
<td><strong>Clarify the individual’s experience and regard for previous help.</strong></td>
</tr>
<tr>
<td><strong>PROBE IF DOES NOT DESCRIBE USEFULNESS OF HELP RECEIVED:</strong></td>
</tr>
<tr>
<td>What types of help or treatment were most useful? Not useful?</td>
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<tr>
<td><strong>BARRIERS</strong></td>
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<tr>
<td>(Coping and Help Seeking, Religion and Spirituality, Older Adults, Psychosocial Stressors, Immigrants and Refugees, Social Network, Clinician-Patient Relationship)</td>
</tr>
<tr>
<td><strong>Clarify the role of social barriers to help seeking, access to care, and problems engaging in previous treatment.</strong></td>
</tr>
<tr>
<td><strong>Probe details as needed (eg, “What got in the way?”).</strong></td>
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<tr>
<td>13. Has anything prevented you from getting the help you need?</td>
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<tr>
<td><strong>PROBE AS NEEDED:</strong></td>
</tr>
<tr>
<td>For example, money, work or family commitments, stigma or discrimination, or lack of services that understand your language or background?</td>
</tr>
<tr>
<td><strong>CULTURAL FACTORS AFFECTING CURRENT HELP-SEEKING PREFERENCES</strong></td>
</tr>
<tr>
<td>(Social Network, Caregivers, Religion and Spirituality, Older Adults, Coping and Help Seeking)</td>
</tr>
<tr>
<td><strong>Clarify individual’s current perceived needs and expectations of help, broadly defined.</strong></td>
</tr>
<tr>
<td><strong>Probe if individual lists only one source of help (eg, “What other kinds of help would be useful to you at this time?”).</strong></td>
</tr>
<tr>
<td>Now let’s talk some more about the help you need.</td>
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<tr>
<td>14. What kinds of help do you think would be most useful to you at this time for your [PROBLEM]?</td>
</tr>
<tr>
<td>15. Are there other kinds of help that your family, friends, or other people have suggested would be helpful for you now?</td>
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<tr>
<td><strong>CLINICIAN-PATIENT RELATIONSHIP</strong></td>
</tr>
<tr>
<td>(Clinician-Patient Relationship, Older Adults)</td>
</tr>
<tr>
<td><strong>Elicit possible concerns about the clinic or the clinician-patient relationship, including perceived racism, language barriers, or</strong></td>
</tr>
<tr>
<td>Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have</td>
</tr>
</tbody>
</table>
### Cultural Formulation Interview (CFI)—Informant Version Cultural Formulation Interview (CFI)—Informant Version (APA, 2013a)

| cultural differences that may undermine goodwill, communication, or care delivery. | different expectations. |
|Probe details as needed (eg, “In what way?”).| 16. Have you been concerned about this and is there anything that we can do to provide you with the care you need? |

Address possible barriers to care or concerns about the clinic and the clinician-patient relationship raised previously.
Cultural Presentations of Distress

Asian youth with depression or anxiety may focus on physical symptoms or use culture-specific bodily idioms to express distress (Groleau & Kirmayer, 2004; Kirmayer, 2001). Medically unexplained symptoms, particularly pain, fatigue, and gastrointestinal and genitourinary symptoms, are common in primary care presentations (Kirmayer et al., 2004). CALD young people are reluctant to reveal psychological and emotional distress to general practitioners because they think such stressors are inappropriate topics for medical attention or they believe that their situation will not be understood (Hollifield et al., 2002). There is limited but emerging evidence that information about associated psychological distress and social predicaments can be elicited by enquiring about the effect of the physical symptoms or other presenting concerns on activities of daily living, stressors, social supports, functioning in work and family, or community contexts (de Ridder et al., 2007; Kirmayer et al., 2004; Peters et al., 2009; Salmon et al., 2004; Salmon et al., 2009). The following table shows that culturally patterned idioms of distress and culture-bound syndromes are linguistic and bodily styles of expressing and experiencing illness, ie cultural ways of talking about distress (Ahmed & Bhugra, 2007). In the case of depression, these often take the form of somatic metaphors as shown in the next section. Knowledge of these cultural idioms can facilitate diagnosis of depression, establish rapport, and minimise the risk of misdiagnosis.

Idioms of Distress and Culture-Bound Syndromes
(Office of the Surgeon General (US), Center for Mental Health Services (US), National Institute of Mental Health (US), 2001).

*Idioms of distress* are ways in which different cultures express, experience, and cope with feelings of distress. One example is *somatisation*, or the expression of distress through physical symptoms (Kirmayer & Young, 1998). For example, the following are common somatic idioms of distress for depression in Indian, Chinese, Middle Eastern and African groups (Bhugra & Mastrogianni, 2004):

<table>
<thead>
<tr>
<th>Somatic Idioms of distress for depression</th>
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<tbody>
<tr>
<td>India</td>
</tr>
<tr>
<td>Nigeria</td>
</tr>
<tr>
<td>Chinese</td>
</tr>
<tr>
<td>Arab cultures</td>
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</table>
Somatic Idioms of distress for depression

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<tr>
<td>• Cardiopulmonary and vestibular symptoms, such as dizziness, vertigo, and blurred vision are common forms of somatisation in Chinese people (Hsu &amp; Folstein, 1997).</td>
</tr>
<tr>
<td>• In African and South Asian populations, somatisation sometimes takes the form of burning hands and feet, or the experience of worms in the head or ants crawling under the skin (APA, 1994).</td>
</tr>
<tr>
<td>• Culture-bound syndromes are clusters of symptoms much more common in some cultures than in others. For example, some Chinese clients display Shenjing shuairuo – a condition characterised by physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and autonomic nervous system disturbances.</td>
</tr>
<tr>
<td>• A culture-bound syndrome from Japan is taijin kyofusho. This syndrome refers to an individual’s intense fear that his or her body, its parts, or its functions displease, embarrass, or are offensive to other people in appearance, odour, facial expressions, or movement.</td>
</tr>
<tr>
<td>• Zar is a term used in a number of countries in North Africa and the Middle East to describe the experience of spirit possession. Possession by spirits is often used in these cultures to explain dissociative episodes (sudden changes in consciousness or identity) that may be characterised by periods of shouting, banging of the head against the wall, laughing, singing, or crying. Affected people may seem apathetic or withdrawn or refuse to eat or carry out their usual responsibilities.</td>
</tr>
<tr>
<td>• Brain fag is a term used in Nigeria and in East and Southern African countries in reference to mental exhaustion in students (Ayonride et al., 2015). The distinctive symptoms of the syndrome are: intellectual impairment; sensory impairment (chiefly visual); somatic complaints, most commonly of pain or burning in the head and neck; other complaints affecting the student’s ability to study; an unhappy, tense facial expression; and a characteristic gesture of passing the hand over the surface of the scalp or rubbing the vertex of the skull. The symptoms most often present during periods of intensive reading and study prior to examinations or sometimes just following periods of intensive study. The client generally attributes their illness to fatigue of the brain due to excessive “brain work” (Prince, 1960).</td>
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<tr>
<td>• Numerous other culture-bound syndromes are given in the DSM-V “Glossary of Culture-Bound Syndromes”.</td>
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<tr>
<td>• The DSM-V offers an adaptive interview technique, the Cultural Formulation of Diagnosis (APA, 2013a) to compensate for the cultural insensitivity of diagnostic instruments. Cultural interviews provide additional information on the client’s life context and perceptual meanings and can ultimately facilitate comprehensive care (Marsella &amp; Kaplan, 2002). Assessing a client’s cultural and religious perspectives, health beliefs and practices, and perceptions of health and illness is important to make a comprehensive, culturally sensitive assessment (Lonner &amp; Ibrahim, 2002). See the Assessing Migrant and Refugee Children and Adolescents section for further information.</td>
</tr>
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</table>
Somatic Idioms of distress for depression


Further information on cultural presentations of distress and culture-bound syndromes can be accessed on the following links:


Help-seeking Behaviours

The New Zealand Youth '07 survey reported that 20 percent of Asian male students and 31 percent of female students reported ‘poor’ mental and emotional health. In particular, Indian students reported higher than average symptoms of mental illness (Yeo, 2012). In New Zealand, schools tend to make the most referrals to child and adolescent mental health services, where social, interpersonal and family problems are of concern. Referrals made by caregivers are often influenced by culture and the caregiver’s perceptions of emotional and behavioural problems. Many studies of mental health in Asian and refugee background communities highlight family’s behaviours of hiding mental illness, which involves not actively seeking treatment and keeping an individual’s problems hidden from the community. Treatment is seen as a last resort, only to be used when the family member’s problems have deteriorated to the point where they can no longer be handled within the family (Cheng et al., 2010; Morrison & Downey, 2000; Wynaden et al., 2005).

Some Asian, Middle Eastern and African clients may seek alternative treatments, including the use of traditional medicines, prayer and visiting temples and churches (Ho et al., 2002). Some prefer seeking help from GPs from the same country of origin, based on the belief that these GPs have a better cultural understanding of their mental health problems. Others will seek non-culturally matched GPs to maintain confidentiality and to reduce the likelihood of information being divulged to their community (Wynaden et al., 2005).

People from Asian/MEA backgrounds are more likely to somatise, ie, report physical rather than psychological symptoms (Ho et al., 2002; Wynaden et al., 2005). This can lead to misdiagnosis or under-diagnosis of mental health disorders (Ineichen, 2008; Leong & Lau, 2001). Leong and Leach (2010) stress the need to understand Asian beliefs and attitudes towards mental health, as their delay in help-seeking behaviours can mean that by the time client’s make their first visit to mental health services, the client may already have elevated levels of distress and hopelessness, and clinicians may have to attend to the first meeting as an emergency situation (Ho, Au & Amerasinghe, 2015).

Working with families (Kirmayer, 2011)

Senior members of families from collective cultures expect to be consulted about any health problems that their child/adolescent has and to accompany the young person to health appointments. The tendency to focus on the young person as the client must be supplemented by close attention to the family system and social network, which can include crucial members in other countries. It is important to acknowledge and welcome family members who accompany the child or adolescent client. Rather than excluding them because of privacy, meeting family members together before meeting alone with the client can be an important step to building trust and a source of valuable information.
Rules of confidentiality and disclosure should be applied in a way that respects cultural context. For CALD families, the cultural legitimacy of parental authority over adolescents should be taken into account. For counseling and treating youth, interventions should be framed in ways that avoid alienating family members or aggravating intergenerational conflicts. Similarly, disclosure of diagnostic issues and family “secrets” (eg, about traumatic events) should be approached carefully, with an understanding of what is at stake for the family. When ambivalence towards treatment or non adherence is an issue, involvement of such mediators as a key family member or trusted family ally in discussions of the different treatment alternatives can strengthen the therapeutic alliance, empower the family and provide necessary support to the client (Kirmayer, 2011).

**Traditional healing**

Use of multiple sources of help is common among migrants, who may consult traditional forms of healing as well as biomedical practitioners (Kirmayer, 2011; Kleinman, 1980). If medications are being considered or prescribed, it is important to enquire about whether the client is using any home remedies or complementary medicine that might interact with the metabolism and effectiveness of a prescribed drug (Lin, Smith & Ortiz, 2001). Broad questions about the use of any medication, food or substance taken for health or medicinal purposes can be followed by specific questions about the use of commonly available substances, such as *Ginkgo biloba*, and about whether clients receive medicines from family, friends or country of origin. Finally, questions about previous or ongoing consultations with a doctor, healer or helper from their own or other communities can uncover medication use or other health concerns that can affect adherence, treatment response and coping (Groleau, Young & Kirmayer, 2006).
Common Conditions

International studies of mental health disorders in young Asian, migrant and refugee populations show trends in common conditions for children and adolescents compared with western populations. For example, a Singaporean study of children aged 6–12 years shows the prevalence of emotional and behavioural problems are comparable to European and Australian studies at 12.5 percent of the population (Woo et al., 2007; Barkman et al., 2005; Sawyer et al., 2001). The same study also found the prevalence of internalising disorders (depressive disorders; anxiety disorders and somatic pain) to be more than twice that of externalising disorders (attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD)), in contrast to studies in the general population in the West which showed externalising disorders to be either as common as or in excess of internalising disorders (Costello et al., 2003; Ford et al., 2003; Woo et al., 2007; Sawyer, et al., 2001). Similarly, Thai and African children were also found to exhibit more over-controlled or internalising behavior (Woo et al., 2014). A Singaporean community study that validated a depression scale for adolescents estimated the prevalence of depression to be between 2 and 2.5 percent which is comparable with rates in western countries (Woo et al., 2004).

In the Singapore burden of disease and injury study, among those below the age of 14 years, autism spectrum disorder was the top cause of disease burden while attention deficit hyperactivity disorder (ADHD) and anxiety/depressive disorders ranked as the third and fifth leading causes respectively (Phua, 2009). For those in the age group 15 to 34 years, anxiety/depressive disorders and schizophrenia were the top two leading causes (Phua, 2009). Primary and secondary school students in a Singapore study have a prevalence of pathological gaming of 8.7 percent (Choo et al., 2010), which is much higher than that reported in European adolescents but lower than for Hong Kong youth (Mülle et al., 2014; Wang et al., 2014). When followed up longitudinally, pathological gamers appeared more likely to develop depression, anxiety, social phobia, and to have poorer school performance (Gentile, 2011).

The suicide rate is one of the surrogate indicators to measure the mental well-being of a population. In New Zealand, suicide is the third highest Potentially Avoidable Mortality (PAM) cause for Asian populations 0-74 years in the Auckland region, representing 11.7 percent (45) of deaths between 2008 and 2010 (Walker, 2014). In New Zealand, as in Asian countries (Chia et al., 2010; Lim et al., 2015), despite suicides in those under 20 years being less frequent compared to older people, there is an increasing trend towards suicide in young populations (10 – 24 years) (Au & Ho, 2014), and unlike other populations the ratio of female to male suicides is higher among Asian than non-Asian populations.
Studies in refugee resettlement countries find high levels of distress and depression among young refugees (Fazel et al., 2005; Kinzie et al., 1986; Lustig et al., 2004; Stein et al., 1999). During the premigration period, refugee children and their families face trauma and loss, social upheaval and disruption to their social and educational development. During refugee flight, many youth are separated from their parents and no longer have the emotional, physical and financial support of their relatives. Unaccompanied minors and children with unstable living situations are at particularly high risk for mental health problems (Bean et al., 2007; Michelson & Sclare, 2009; Nielsen et al., 2008; Weise & Burhorst, 2007). In new countries, youth often face acculturative stress and family poverty (Simich et al., 2006). Refugee children and adolescents must learn a new language, renegotiate their cultural identity, and deal with social isolation, racism, prejudice and discrimination (Montgomery & Foldspang, 2008). As youth acculturate, many come into conflict with parents and relatives who hold ideals and values different from those being adopted by their children.

Among the common presentations to CAMHs of children and adolescents from Asian, Middle Eastern and African (Asian/MEA) backgrounds are: mood disorders (depression, bipolar disorders, self-harm, suicidality); anxiety disorders; obsessive compulsive disorders; psychosomatic disorders; stress-related and adjustment disorders; posttraumatic stress disorder; attention deficit hyperactivity disorder (ADHD), developmental disorders, autism spectrum disorder (ASD), psychotic disorders, eating disorders; sexual identity issues; Internet Addiction Disorders (IAD) and drug, alcohol and gambling addictions (Kirmayer et al., 2011). Some of these presentations are explored in the following sections.

**Depression and anxiety**

This section presents an overview from the international literature of the prevalence and manifestation of depression and anxiety in Asian adolescents and discusses some of the issues in assessment and diagnosis in this population. Studies suggest that Asian youth in settlement societies and girls in particular are at higher risk of Major Depressive Disorder (MDD) than among Asian youth in Asian countries, and researchers have speculated that the difference may be due to acculturative stress (Kalibatseva & Leong, 2011; Yang & WonPat-Borja, 2007). The chief symptoms in major depression in the West are considered to be sadness or depressed mood. However, people from Asian and other ethnic minority backgrounds who suffer from major depression are more likely to present to their general practitioner (GP) with somatic complaints such as changes in appetite, headaches, backaches, stomach aches, insomnia, or fatigue (Kleinman, 1996); and they may be less likely to be diagnosed with a mental disorder (Ahmed & Bhugra, 2007).

Studies suggest that depressive symptoms may cluster in a different way in Asian groups (Edman et al, 1999; Lu et al., 2010). For example, the Center for Epidemiological Studies Depression Scale (CES-D) assesses four domains of depression: negative/depressed affect,
positive affect, interpersonal problems, and somatic symptoms (Radloff, 1977). Edman et al. (1999) found that in a sample of Filipino American adolescents, only two factors provided a reasonably good fit. Lu et al. (2010) examined the CES-D in a sample of Hong Kong Chinese and Anglo American students. While the authors found support for four factors in both samples, they observed a tendency among the Chinese participants to report somatic symptoms and a tendency among Anglo Americans to report both somatic and affective symptoms. Furthermore, Lu et al. (2010) concluded that American participants considered somatic and affective experiences as two different dimensions that comprise depression equally, and Chinese participants were more likely to report their somatic symptoms, as opposed to their depressed feelings despite their awareness of the psychological problem. The observed tendency among the Chinese participants to concentrate on somatic symptoms is arguably more socially acceptable and may be related to the assumption that a cure can be found more easily for physical complaints (Lu et al., 2010).

Kim et al. (2011) examined the relationship of English proficiency and depressive symptoms in a sample of Chinese American adolescents. They found that self-reported low English proficiency in middle childhood was related to later reporting of accented English in high school, which, in turn, related to their perception of being labelled as perpetual foreigners. Both boys and girls who internalised the perpetual foreigner stereotype experienced more discrimination and reported more depressive symptoms than the adolescents who did not identify as perpetual foreigners.

The impact of acculturation
Examining how the unique experiences of acculturation affect adolescent development is important because this is a period when identity development is central (Sirin et al., 2013). During adolescence, migrant youth are actively exploring the extent to which they identify with their ethnic culture (Berry, Phinney, Sam, & Vedder, 2006; García Coll & Marks, 2009). For CALD adolescents, identity development may hold unique tasks and challenges such as dealing with discrimination, and/or navigating competing cultural demands (Fine & Sirin, 2007; García Coll & Marks, 2009). Youth who are immersed in the process of acculturating may be experiencing acculturative stress and it is important to examine the extent to which this leads to internalising mental health symptoms.

Sirin et al. (2013a) in a longitudinal American study of mental health symptoms for migrant adolescents found that greater exposure to acculturative stress predicts significantly more withdrawn, somatic, and anxious/depressed symptoms. Although for many families the
process of migration results in opportunity, there is significant stress involved in the journey, with profound implications for the psychological development and identity formation of migrant youth (Sirin et al., 2013a). Broadly defined, acculturation is the process of negotiating social and cultural norms between two or more cultures that typically involve home (country of origin) and host cultures (Berry, Poortinga, Segall, & Dasen, 1992; Graves, 1967). Acculturative stress refers to the potential challenges migrants face when they negotiate differences between their home and host cultures (Berry, 1997; Berry, Phinney, Sam & Vedder, 2006). Such stress arises from multiple aspects of the acculturation process, such as learning new and sometimes confusing cultural rules and expectations, dealing with experiences of prejudice and discrimination, and managing overarching conflict between maintaining elements of the old culture while incorporating those of the new (Berry, 1997; Suárez-Orozco & Suárez-Orozco, 2001).

Acculturative stress also arises from negative stereotypes and attitudes that the host culture might harbour about migrants in general (Mahalingam, 2006; Rumbaut & Portes, 2001). Studies of racism and discrimination in New Zealand and internationally, have provided strong empirical evidence that youth who experience minority stress during the identity formation process are at greater risk for depression, anxiety, and psychosomatic complaints (Fisher, Wallace, & Fenton, 2000; Lorenzo, Frost, & Reinherz, 2000; Romero & Roberts, 2003; Scragg, 2016).

As levels of acculturative stress increase, internalising mental health symptoms increase as well (Sirin et al., 2013a). Acculturative stress is a critical component of mental health for migrant youth. Sirin et al.’s (2013a) study found that toward the later high school years, (around 17-18) there is an increase in anxiety/depression and somatic symptoms in migrant youth. There are gender and generational differences in mental health symptoms. Girls reported more anxious/depressed and somatic symptoms in the 15-18 age groups and more withdrawn/depressed symptoms in 15-18 years age groups than boys did. Generational differences are also evident in acculturative stress. First-generation youth experience higher levels of acculturative stress than second-generation youth do overall (García Coll & Magnuson, 1997; Suárez-Orozco & Suárez-Orozco, 2001).

Mental health professionals should be aware of both the stressful effect of acculturative stress, but also the important role that social support plays in buffering this effect. Without such consideration, it is more likely that a professional could see the adolescent’s mental health symptoms as pathological, rather than as a normal reaction to external pressures (Sirin et al., 2013b). Putting strong social support in place for students who are experiencing negative mental health symptoms and/or high acculturative stress could be an effective aspect of intervention. Mental health practitioners, as well as being a source of social support, can help identify other sources of support as well, whether through increasing family connections with family therapy, increasing friendships through groups or
interventions to improve social skills, or by directing clients to community services they may not be aware of (see the Resources section).

**Assessing adolescent depression**

The Beck Youth Inventory-2 (BYI-2) is one of the most popular scales for evaluating the severity of depression in adolescents (Beck, Beck & Jolly, 2005). The prevalence of depression increases during adolescence and studies have shown that the BYI-2 is a reliable tool for measuring the severity of depressive symptoms in Asian adolescents (Lee et al., 2017; Wu & Huang, 2014) although it has not been validated for Asian populations.

The Children’s Depression Inventory (CDI) is one of the most widely used instruments for assessing the presence and severity of depressive symptoms in children and adolescents (age 7–17) (Kovacs, 1992). While the CDI has established good reliability and validity for describing depressive symptoms in Western populations it has not been validated for Asian, Middle Eastern or African populations and therefore be used alongside clinical and cultural assessment tools.

Examining depression as a multidimensional construct that consists of various symptoms, as opposed to concentrating on the affective aspect of depression may improve diagnosis and treatment of depression in Asian/MEA adolescents. Considering other variables that play an important role in a young person’s life such as gender, ability to acculturate and to speak English, may prove to be crucial in the assessment, diagnosis, and treatment of depression among adolescents from CALD backgrounds (Kalibatseva & Leong, 2011).

In order to make accurate diagnosis across cultural boundaries and formulate treatment plans acceptable to the client, the DSM-V (American Psychiatric Association, 1994; 2013a; 2013b) proposes the use of the Cultural Formulation (CF) as a systematic model for cultural assessment (see Cultural Formulation section). The ICD-10 may also be a useful reference (International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, 2011; Tasman et al., 2014).

Cultural Formulation is designed to supplement a standard clinical evaluation by highlighting the effect of culture on the client’s identity, personality development, symptoms, explanatory models of illness, help-seeking preferences, stressors and supports, therapeutic relationships and outcome expectations (see Assessing Migrant and Refugee Children and Adolescents section). Information on culturally appropriate psychosocial approaches to intervention and treatment are discussed in the section on “Psychosocial Interventions”.
Autism spectrum disorders (ASD)

When children with autism spectrum disorders (ASDs) are from CALD backgrounds, the clinicians assessing need to understand how cultural and linguistic differences may affect identification, assessment, and treatment strategies (Dyches, 2011). For example, tantrums, aggression, attachment, eye contact, social interactions, communication, and emotional expression may be viewed symptomatically rather than culturally (Wilder, Dyches, Obiakor, & Algozzine, 2004). Subsequently, CALD children with ASDs may be misclassified, for example with developmental delays, intellectual disabilities, specific learning disabilities, speech-language impairments, multiple disabilities or emotional disorders or not classified at all, particularly if the child displays mild symptoms that may be confused with cultural differences rather than disabilities (Noland & Gabriel, 2004; Mandell, et al., 2009; Shattuck, 2006).

ASD Screening

Although the general characteristics of autism appear to be universal across cultures (Ametepee & Chitiyo, 2009; Papageorgiou, Georgiades, & Mavreas, 2008; Wakabayashi et al., 2007), parental recognition of and concern about the symptoms are not consistent. The three primary diagnostic characteristics of autism—social interaction, communication, and restricted behavioral repertoire—may be interpreted through a cultural lens that can lead to under-, over-, or mis-diagnosis (Dyches, Wilder, & Obiakor, 2001).

Formal and informal assessments of basic interpersonal communication skills (BICS) and cognitive academic language proficiency (CALP) are critical for CALD children being tested for ASD eligibility, including for children who are non-verbal. Under ideal circumstances, a student learning English as a second language could acquire BICS within 6 months to 2 years, whereas CALP takes 5–9 years to develop, depending on age and other factors. However, developmental trajectories may differ for students with ASD. For example, CALD students with mild ASD may develop CALP at a much faster rate than BICS; students with autism who also have intellectual disabilities may develop both BICS and CALP at slow rates; and some CALD students who have ASDs may remain in the silent period for much longer than typically developing CALD students (2–6 months) (Dyches, 2011).

Clinicians need to be cautious when viewing test items through a cultural lens. For example, several items on the Modified Checklist for Autism in Toddlers (M-CHAT) may not necessarily be autism “red flags” because of cultural considerations. Three items dealing with pointing (Does a child point to ask for or to indicate interest in something? Does a child look at something the parent points to?) may not be relevant to those from cultures in which pointing (Chinese, Korean, Vietnamese, Thai etc) is rarely used because it is considered rude. Another item that asks about a child’s eye contact may not be valued by those who consider children making eye contact with adults as rude, threatening, or disrespectful. The meaning
CALD parents attribute to autistic symptoms can differ greatly (Dumont-Mathieu & Fein, 2005; Zhang, Wheeler, & Richey, 2006), and the failure of CALD parents to identify these behaviours as problems may delay or otherwise affect the identification of the child as at risk of having ASD (Dyches, 2011).

Similarly, many instruments include items that require caution during administration and interpretation. Along with items regarding pointing and eye contact, clinicians should consider cultural differences in the use of sarcasm, seeking attention from adults, use of physical touch, use of voice intonation and inflection, control of the direction and length of conversations, use of personal space, and use of gestures, among other culturally based communicative interactions. Clinicians are encouraged to probe these culturally based differences to differentiate between cultural expectations and ASD symptoms. However, if the child has never observed parents pointing at an object to express interest, it is not likely that pointing will be in the child’s repertoire, regardless of whether an ASD exists or not. In such cases, clinicians need to conduct a thorough examination across many scenarios (Dyches, 2011).

Cultural and linguistic variables may contribute to challenges in identifying children with ASD and contribute to the disparity in the diagnosis of ASD among some ethnic groups (Begeer, El Bouk, Boussaid, Terwogt, & Koot, 2009; Dyches, 2011). While the core characteristics of ASD are common across cultures, parental response to the symptoms are not (Dyches, Wilder, & Obiakor, 2001). Signs and symptoms that are clearly "red flags" in western health or education systems may not be viewed in the same way for someone from a culture that may not define the disorder. One factor contributing to the inaccurate classification and diagnosis of children with autism is the "families' cultural and linguistic interpretation and reaction to receiving the diagnosis and to obtaining services" (Wilder, Dyches, Obiakor, & Algozzine, 2004, p. 106). Some cultures stigmatise disability and families may feel that a child with a disability is something that needs to be hidden from other families and the community, which may influence the type of care the family seeks (Wang & Casillas, 2012).

Tips for screening for ASD in CALD families (Gabovitch, 2014)

**Assessment process**

- When conducting assessments, consider the client/family’s level of acculturation.
- An assessment may have to be completed over multiple sessions if there is a need to assess a child in more than one language, collaborate with an interpreter, utilise alternate assessment formats, and find and/or establish norms for a given client population.
- Discuss the family’s comfort with speaking and understanding English and where required provide an interpreter at all appointments. Ensure that the family understand that the interpreter is bound by DHB privacy and confidentiality policy.
• Use a translated screening tool when available (see- http://mchatscreen.com/mchat-rf/translations/).

• Reinforce that such an assessment is part of standard care since the concepts of screening, early identification and early intervention may be unfamiliar for families from CALD backgrounds. For many families, these concepts are culturally bound and they may perceive that their children will be stigmatised in their communities by participating in these practices.

• Stress that early diagnosis and intervention is associated with better development and improved functioning for their child, in the long-term.

• Practitioners need to determine how familiar and comfortable the client/parents/grandparents are with testing practices, as familiarity with testing procedures may influence performance during the assessment process.

• Remember that in some families, questions about a child’s skills may go unanswered since they may feel intrusive. Some families may view screening as “looking for trouble” or feel that things clinicians think are problems are not an issue. Still for other families, their responses may shed light on their ability, background or resources. Thus, communicating slowly and clearly while listening carefully and fully engaging families produces the best results.

• It is equally important to ask questions about the family’s understanding of and expectations for child development. This could provide a wealth of information and set the stage for effective communication about child development in general and their child’s development specifically.

• Schedule a follow up visit for one or two weeks after the assessment to talk through what happened at the visit.

• More persistent follow up to keep families engaged may be required.

**Explaining the screening questions**

• Consider whether parents understand the screening questions because terms used in screening tools may have different meanings when interpreted. Consider literacy level, as well as language. Interpreters and culturally matched staff (who are proficient in distinct cultural issues) can assist greatly since written screening tools may be difficult for some families to complete, and for clinicians to interpret.

• Taking time to explain the screening questions is critical to being certain that CALD families understand and answer questions accurately.

• It is important to consider that some terms may not exist in the client’s language. In addition to providing an interpreter, it is important to provide written translated information for parents. Parent information can be downloaded from http://www.maactearly.org/translated-materials.html.

**Communicating concerns about child development**

• Communicating concerns about a child’s development in a different language or across cultures can sometimes be tricky. While having a general understanding about the cultural group you serve may help in anticipating particular reactions or issues, clinicians
must avoid stereotyping. Each family is distinct, irrespective of their cultural identity. When discussing screening concerns, miscommunication can often be avoided by starting with the families’ perspective.

- **Ask questions as an invitation for parents to tell you what they are thinking, such as:**
  - “Do you have any concerns about your child’s development?”
  - “What do you think is the cause of this concern?”

- **Clinicians should express their concerns only after the family’s perspective has been shared, but they should also be mindful that families may not see a concern, especially if they are first time parents. Targeted questions about the child’s behaviour, communication, play, and interactions with other children and adults help clinicians probe further. When the issue is a failed or positive screening test, it is important to emphasise that it identifies only that a child is at higher risk for ASDs. It is not a diagnosis.**

- **Be careful about using the word “autism” if families do not ask you about it specifically. If they do, it is critical to ask:**
  - “What have you heard about autism?”
  - “What does the term “autism” mean to you?”

- **Reassure parents that when a child has problems with talking, interacting, or behaviour, there are many things that can help a young child develop these skills.**

More information about considering culture in autism screening and translated screening tools can be downloaded from the following sites:


The following case study illustrates culture and language issues in screening for autism. The case study provides a question for viewers to consider and reflect on. **Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.**

**Case Study 2: Screening for autism (Vietnamese)**

(Adapted from Massachusetts Act Early (MA Act Early), (2017)).

Mrs Buivan arrives for an appointment with her three year-old Tran. Tran’s mother speaks only Vietnamese so you call the telephone interpretation line because you were not aware that an interpreter would be required. Through the interpreter, Mrs Buivan reports that she is worried because Tran only uses three to four words and has “bad” behaviour, such as temper tantrums and not listening. He also sleeps poorly and is a picky eater.
Mrs Buivan shares that she has been concerned about Tran since before he turned two. He is very different from his two older sisters. She shared her concerns with the Plunket Nurse at Tran’s 24-month well-child visit, but was told that boys often talk later than girls, he was hearing both Vietnamese and English at home (through television and his sisters), and she needed to be more consistent with discipline.

Tran, his sisters, and mother live with her parents who also believe that as Tran is a boy, he will talk later, especially because he has two sisters who are more than willing to speak for him. His mother feels there is something more going on and has decided to seek help from the local Child Health Service (who subsequently referred to CAMHs), after her friend told her that they had helped them find a special education classroom for their pre-schooler with a developmental delay.

You observe Tran and are concerned that he does not use any words and wanders around the clinic room without purpose. You want to complete an M-CHAT with the family but do not have a Vietnamese copy. You then remember it is available online and download a copy that his mother completes (http://mchatscreen.com/wp-content/uploads/2015/10/M-CHAT-R_F_Vietnamese_v4.pdf).

Mrs Buivan endorses three critical items and you review these with the telephone interpreter who confirms that these are accurate responses. You revisit Mrs Buivan’s concerns and support her sense that Tran needs a more detailed evaluation which she requests you help arrange at a follow up appointment. You also encourage her to enrol Tran at a pre-school since at age three, he is eligible for subsidised pre-school education.

| Question 1: What steps are important in engaging with the family? |
| Question 2: What questions should you ask parents? |
| Question 3: How best can you support the parents towards accepting early intervention? |

*Discussion notes are available under the “Case studies-discussion notes” section.*
Attention deficit hyperactivity disorder (ADHD)

Research shows that culture can directly affect both assessment and treatment of Attention Deficit Hyperactivity Disorder (ADHD) (Pierce & Reid, 2004; Pham, 2013). This section provides an overview of cultural perspectives on ADHD and the effects of cultural differences on the assessment and treatment of ADHD.

Cultural perceptions of child behaviour
Cultural perceptions of child behaviour and ADHD treatment are likely factors that contribute to the underestimation of Asian children with ADHD and the underutilisation of ADHD treatment (Cuffe et al., 2005).

• Cultural differences in parental expectations about children’s behaviour, in parental coping strategies, and in their beliefs about the causes and treatment of disruptive symptoms are likely to contribute to inequalities in diagnosis and treatment of ADHD among Asian families (Garland et al., 2005). In determining whether a child has a mental health disorder, such as ADHD, Asian groups may use different criteria from those used by non-Asian families (Dinh & Nguyen, 2006). Additionally, traditional Asian perspectives concentrate less on psychopathology and more on enlightenment and ideal mental health (Lau & Takeuchi, 2001). For example, lower rates of ADHD diagnosis in East Asian countries may be attributed in part to a background of Confucianism (Moon, 2012; Young, 2012). Chinese, Korean and other East Asian societies value highly education, harmony with others, and respect for parents and elders. This cultural environment of high parental expectations and clear direction about expected behaviours may contribute to different rates of reporting the symptoms of ADHD (Moon, 2012).

• Cultural values influence parental attitudes, leading to different thresholds regarding how they view and tolerate children’s behaviour problems (Eiraldi et al., 2006). This also will in part determine how likely it is that parents are to seek help through clinical intervention for their children and for what purpose. For example, although Asian parenting styles tend to be more directive than that of non-Asian families, a relaxed parenting style is used with children younger than 6 or 7 years of age (Jose et al., 2000). Therefore, an underrepresentation of Asian families receiving mental health or psychiatric services may be partially due to Asian tolerance of a wider range of preschool behaviour than in non-Asian families. Asian parents may have different standards for what is considered a severe impairment and behaviour problem, than other parents (Norvilitis & Fang, 2005). Moreover, because symptoms of ADHD occur before age of 7, many Asian parents might not be aware of or report concerns with their child’s behaviour during that age range.

• The typical childhood behaviour problems thought to be of clinical concern in Western culture might not be perceived as severe by many Asian families. Asian parents often
hold high expectations for their child’s behaviour, and they may be reticent about reporting children’s problems (Nguyen et al., 2004). For example, many Asian parents believe that personal effort and discipline are important factors leading to academic and personal success (Zadeh et al., 2008). Parents instil these beliefs early in childhood, so children are likely to compensate for behavioural difficulties by exerting effort and concentration in their schoolwork. This may be seen as a protective factor for most Asian families, as these qualities encourage family stability, structure, and an internal locus of control. However, childhood behavioural problems may not be acceptable to many Asian parents because such difficulties reflect on the whole family (Kramer, Kwong, Lee, & Chung, 2002). Thus, parents may not be willing to reveal or admit such personal matters to teachers and health professionals in order to avoid stigmatisation.

• When a child coming from a stable family does exhibit significant inattentive or hyperactive behaviours that lead to decline in academic achievement at school, parents are likely to become concerned since they place much emphasis on the child’s academic success (Sue & Sue, 2003). Parents see teachers as professionals with authority over schooling, but they may attribute their child’s negative behaviours to a teacher’s lack of classroom management, discipline, or instruction, especially if parents do not witness such behaviours at home.

Assessment and treatment
When assessing and treating children from CALD groups, it is evident that extra precautions must be taken (Moon, 2012; Pierce & Reid, 2004; Young, 2012). Research shows that culture can directly affect both the assessment and treatment of ADHD (Pierce & Reid, 2004). This section provides an overview of the effects of cultural differences on the assessment and treatment of ADHD. Cultural difference may also have an impact on access to treatment and compliance with treatment programmes (Pierce & Reid, 2004; Young, 2012; Zhang et al., 2005). For example, children from CALD groups discontinue treatment before completion at a much higher rate than do Europeans (Bussing et al., 1998; Young, 2012)

Assessment
Conners Behaviour Rating Scales (2008) and other child behaviour scales are used to examine whether a child exhibits challenging behaviour which falls outside the range of expected age-appropriate behaviour. Such behavioural concerns may include difficulties around hyperactivity, impulsivity, aggression, sustaining attention and/or disruptions to peer relations or learning.

Behavioural assessments involve a detailed process. To help formulate an accurate diagnosis they typically require parent interviews to attain a developmental history, coupled with diagnostic questionnaires, teacher interviews and/or school observations and a clinical session with the child. With this knowledge, children and parents can start to better
understand the underlying causes of challenging behaviour and formulate treatment plans to modify both the behaviour itself and its impact on everyday life.

**Cultural Considerations and Implications**

- Two main issues arise when children from CALD groups are assessed for ADHD:
  - There is the possibility of rater bias. (Note that the term bias is used in the measurement sense and refers to systematic error which can over or under estimate true scores). Sonuga-Barke et al. (1993), describe two ways rater bias can affect assessment: (1) individuals from CALD groups conducting assessments may have different understandings of what constitutes disorder or may use different criteria to diagnose the same disorder, and (2) the same individual may diagnose people from CALD groups differently even when they present the same type of symptoms in equal severity.
  - The second issue that arises concerns normative use of behaviour rating scales in the assessment process. Behaviour rating scales were developed without consideration of cultural differences (Bauermeister et al. 1990). As a result, there are concerns pertaining to their normative use with CALD groups. Groups from CALD backgrounds are not adequately represented in the norm groups of many of the available behaviour rating scales (Reid, 1995).

- Clinicians must be aware of possible cultural differences in tolerance for ADHD-related behaviours and make sure that they obtain assessment data from multiple sources (parents, teachers and test administrators), to provide a comprehensive view of a child’s symptoms (Theilking & Terjesen, 2017).

- Another concern arises when non–English speaking parents are asked to complete behaviour rating scales. Clinicians need to know how to use interpreters effectively (see CALD 4: Working with interpreters). Some rating scales are now translated. For example, the ADHD Rating Scale IV is translated into Arabic https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2841457/ (Hassan et al., 2009).

**Treatment**

**Behavioural interventions for ADHD**

- Evidence-based behavioural interventions for ADHD, such as parent–child interaction therapy (PCIT), although structured and goal-oriented, require parents to adjust their form of parenting, their cultural values, and their communication with their child (Brinkmeyer & Eyberg, 2003). The goals of PCIT are to improve both parent–child attachment relationships and the behaviour management skills of the parent by establishing effective limit setting and consistency in discipline. This may create conflict with Asian parents who may feel that their own parenting skills are being criticised (Pham, 2013).

- The IYP programme has been shown to be an effective, strengths-based approach to improving parenting in Asian families, when it is culturally and linguistically tailored
The Incredible Years Programme (IYP) is designed to help parents deal with their children’s difficult behaviours (Webster-Stratton, 2009). The aims of the IYP are to support parents to: increase the amount of praise for their children and reduce the use of criticism and negative commands; to set limits for children, replacing hitting and harsh discipline with non-violent discipline techniques; to increase the monitoring of children; to feel more confident about themselves and their parenting skills; to solve problems and communicate positively with their family; to gain their children's cooperation, leading to a more positive relationship with them.

- Parental expectations that are less consistent with the goals of the intervention also lead to low participation and retention rates. Asian parents expect concrete goals and strategies focused on solutions (Lau & Takeuchi, 2001). They frequently expect immediate results in their child’s behaviour. However, for children with ADHD, it may take at least several weeks or months for behaviour treatments or psychotropic medications to become effective in order to see an improvement in their behaviour.

- Working with parents directly on more concrete short-term behavioural goals will allow parents to see the immediate benefits of the intervention, and thus be more likely to continue with the intervention. Parents initially may be reluctant to share information about their own parenting styles and experiences. However, Asian parents can become empowered by sharing their parenting experiences where they have been effective or ineffective (Webster-Stratton, 2009). This is critical to successful parent engagement because it provides a context for treatment, engagement and planning. When parents are willing to share their goals of treatment, mental health professionals can determine what is important to them and adapt treatment plans based on these shared goals.

**Pharmacotherapy**

- Asian parents often do not comply with their medication regimen if they do not see immediate therapeutic effect or changes in their child’s behaviour (Nguyen et al., 2004). If parents are not informed about medication dosages and schedules or the purposes of the medication prescribed, they may discontinue treatment altogether.

- Prompt parents to ask questions.

- It is best to start low and go slow in prescribing medications and tailor medications for each child. There may be significant differences among some cultural groups in response to medication, such as their ability to metabolise or respond to psychotropic medications such as those used to treat ADHD (eg Ritalin) (Dawkins, 1996). Studies show that the cultural differences in clinical response to pharmacological medications may be a result of a higher prevalence of slow metabolisers in minority populations (Lawson, 1996). When CALD children are receiving pharmacological treatment for ADHD, it may be beneficial to closely monitor their behaviour and mental and physical health. Doing so may help catch any harmful side effects early so that adjustments can be made.
**Cultural Considerations and Implications**

- Cultural issues can have a significant impact on the treatment of ADHD (Livingston, 1999; Pham, 2013). Cultural matching of clients and therapists may improve treatment adherence and outcome (Rosenheck et al., 1995).
- Aim to get both parents to appointments as parents may have different child rearing views and parenting approaches.
- CALD parents may lack knowledge about ADHD (Pham, 2013). Different beliefs about ADHD and the need for treatment may affect treatment cooperation (i.e., following through with prescribed treatment interventions) (Lawson, 1996).
- Providing education to families of children from CALD groups about the nature of ADHD as a mental health disorder that is best treated by mental health clinicians, may improve treatment outcomes.
- The use of multimodal therapy (i.e., integrating pharmacotherapy with several educational or psychotherapeutic approaches) can maximise the chances of long-term adjustment (Richters et al., 1995).
- Providing psycho-education to parents and children may increase confidence in health professionals and increase the percentage of children who follow through the entire treatment cycle.
- Education for clinicians about cultural differences in child behaviours, parental styles and how to use interpreters in assessing ADHD is important. It may improve clinicians’ ability to recognise when a child from a CALD background needs treatment (Cuffe et al., 1995).
- Because research has demonstrated that CALD children and families discontinue treatment at a high rate, it is important for clinicians to develop motivational tools and educational programmes to increase adherence to treatment. For example, highlighting to parents that stimulant medications (e.g., Ritalin) have been shown to improve classroom behaviour and academic performance, improve interaction with teachers, friends and family and decrease anxiety (Goldman et al., 1998).

**Psycho-education**

- In order for parents to be more willing to participate in assessment and treatment for ADHD, one important goal is to mitigate the negative influences of shame and stigmatisation on help-seeking behaviour. Information on the prevalence of disruptive behaviour problems among school-age children might help to normalise parents’ experiences across acculturation levels and decrease stigmatisation.
- Psycho-education for parents and educational supports for their children to ensure academic and behavioural success at school can provide motivation to adhere to treatment which may improve outcomes and family engagement with mental health services.
The following case study illustrates help-seeking behavior in regards to ADHD in a Chinese family. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

**Case Study 3: Attention deficit hyperactivity disorder (ADHD) (Chinese)**
(Adapted from Young, 2012).

Jing is a sixteen year old Chinese adolescent. She was born in China but raised in New Zealand from the age of six. Jing is the only child in her family. She says that her parents are understanding of her ADHD symptoms and do not “push” her to excel, although Jing’s parents are both highly educated with graduate degrees. Her father has a Ph.D in a science field and her mother has a Master’s degree in Information Technology. Jing does not indicate that her parents benchmark her success by the use of social comparison with others. Jing attends her local secondary school where she has been a high achiever and was top of her class in maths and science last year. Her aim is to be a doctor. However, recently her grades have dropped. Socially, Jing doesn’t feel that she “fits in” at school. She has a reputation for being a “space cadet,” and she is still somewhat aloof from others, having few friends (none of whom are of Asian descent). Jing considers herself to be “strange” in high school. She feels alone and different from others. Recently, she has had problems focusing on, and staying interested in her studies.

This year Jing came across her ADHD diagnosis by accident. While surfing the internet, she came across an ADHD checklist of symptoms as a method of self-assessment. She was able to endorse most if not all the criteria for ADHD on the self-assessment. Jing provided the self-assessment inventory to her friend so that she could rate Jing. The friend’s assessment results were similar to those obtained by Jing. This provided Jing with the necessary data to approach her parents about her findings. Jing’s parents initially responded in a supportive way. Her parents “always knew something was wrong with” her. Jing’s parents sought the help of CAMHS to address her ADHD symptoms, namely, medication therapy. However, despite their initial support, Jing’s parents eventually stopped her medication therapy due to the possible side effects she was experiencing, including feeling slowed down in her thinking. As well, Jing’s parents do not believe in mental health care, which may also account for their discontinuing psycho-pharmacological intervention. Jing quotes her parents as saying that ADHD “doesn’t exist in China, it was made up just to sell drugs in western countries.” As Jing is their only child, her parents want to provide her with the best opportunity to perform well academically and...
hence they were initially open to allowing Jing to be given medication therapy, despite being dubious about the applicability of the ADHD label to Chinese people.

Since stopping medication Jing’s condition appears to have “spilled over” beyond her academic pursuits to affect her daily routines and personal relationships. Jing reports that she has lost her house keys on several occasions and has also lost her cellphone five times. She loses track of time. She talks about having difficulty successfully interpreting social cues, such as those expressed non-verbally. Jing often forgets to do her household chores, such as emptying rubbish and tidying up after herself. This lack of consideration irritates her parents.

Jing says that she doesn’t know if she really believes in mental illness or ADHD. “I haven’t talked to anyone about it really. I just thought it was how I was. I’m strange. The medication made me feel really slow and I thought, ‘boy is this how normal people feel?’”

Since stopping medication Jing says that she struggles to get out of bed some days. She has difficulty focusing on her school work and says that she is being lazy. Jing reports that the medications were effective in allowing her to focus more as it “slowed her down” and made her feel “normal”.

Neither Jing nor her parents have talked to her school teachers for fear of “losing face”, and of being perceived as being lazy and making excuses for her lack of achievement of recent times.

Jing is not currently in any treatment service. She acknowledges that she was performing better academically when she was taking medication than she is now without medication therapy. Jing is considering going back to CAMHS to restart her medication. She acknowledges her parents’ beliefs regarding medication, but wants to consent to treatment services on her own. Jing is willing to do anything that she thinks will assist her in performing academically.

**Question 1:** What steps are important in engaging with Jing’s parents?

**Question 2:** What information may help Jing and her parents to better understand ADHD?

*Discussion notes are available under the “Case studies-discussion notes” section.*
Problem gambling

“Pathological gambling” refers to a condition in which individuals meet five or more Diagnostic and Statistical Manual V (DSM-V) criteria (APA, 2013a). A person suffering from pathological gambling shows persistent and recurrent maladaptive gambling behavior, resulting in dysfunctions in the areas of work, studies, and social and family relationships. Whereas “problem gambling” refers to a condition in which a person meets three or four DSM-V criteria, and the person has the following problems: high rates of gambling-related fantasy, lying, using gambling to escape, and preoccupation about gambling, “disordered gambling” is used to describe the combination of problem and pathological gambling. Disordered gambling is associated with substantial interpersonal, financial, and legal difficulties, coupled with increased levels of substance abuse, mood and anxiety disorders, and suicidality in some cases (Alegria, 2009).

International studies show that Asian families are disproportionately affected by problem gambling (Blaszczynski, et al., 1998; Cultural Partners Australia Consortium, 2000; Loo et al., 2008; Petry, Armentano, Kuoch, Norinht, & Smith, 2003; Sobrun-Maharaj et al., 2012, Tse et al., 2010). Among Asian groups, Asian people from refugee backgrounds (Marshall, et al., 2009; Petry, et al., 2003) and international students (Gambling Research Australia, 2011; Li, 2008; Li, 2006) are more vulnerable to gambling related disorders (Marshall, et al., 2009; Petry, et al., 2003). In New Zealand, Asian groups from refugee backgrounds include South-East Asians: Laotians, Vietnamese, Cambodian and Burmese groups.

Asian youth gambling behaviours
The New Zealand Youth ‘12 survey included youth gambling behaviours (Rossen, et al., 2013). The results for Asian youth are drawn from the nationally representative survey of secondary school students conducted in 2012. Youth’12 surveyed a large randomly-selected sample of secondary school students. The following results are based on the 1051 Asian students in the study in comparison with the 4024 New Zealand European students. Asian young people included students who identified as Filipino, Chinese, Indian, Japanese, Korean, Cambodian, or ‘Other Asian’. As Asian students constitute a range of ethnic groups, there may be meaningful differences in relation to gambling between the various Asian ethnic groups.

The Youth’12 survey showed that (Rossen, et al., 2013):

- About one-quarter (23%) of Asian students had gambled in the last year, and 9% had gambled in the last four weeks. Of those who had gambled in the past year, very few (5%) spent more than $20 per week or more than 30 minutes a day gambling.
• Rates of gambling in the last 12 months were similar amongst Asian and NZ European students (23% and 24% respectively), as were rates of gambling in the last 4 weeks (9% for both groups).

• Asian students were much more likely to be worried about their gambling than NZ European students (24% of Asian and 6% of NZ European students who had gambled in the past year).

• 57% of Asian students reported that their parent(s)/caregiver(s) gamble and 11% were worried about their parent(s)/caregiver(s) gambling. A number of Asian young people and/or their family encounter problems due to gambling.

Xu (2014) examining the role of social and cultural connectedness in the gambling behaviour of Asian youth found that family, friends and school connectedness scales were not found to be protective towards unhealthy gambling behaviours (p>0.05). However, cultural connectedness was found to be significantly protective against unhealthy gambling behaviours (p<0.05). The finding suggests that prevention and treatment programmes consider encouraging Asian youth to explore cultural connectedness as a form of prevention or treatment.

The following tables identify the variables associated with an increased risk of “unhealthy gambling” (Rossen et al., 2013) and culturally competent assessment and intervention for teenage problem gambling (Tse et al., 2004).

**Risk factors for unhealthy gambling in Asian youth populations**
(Adapted from Rossen et al., 2013, p.104).

<table>
<thead>
<tr>
<th>Risk: Variables associated with an INCREASED risk of “unhealthy gambling.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Worrying about the amount of time/money spent on gambling.</td>
</tr>
<tr>
<td>• Worrying about other people’s gambling (ie family members).</td>
</tr>
<tr>
<td>• Experiencing the following impacts of someone else’s gambling (ie family members):</td>
</tr>
<tr>
<td>- Arguments or fights.</td>
</tr>
<tr>
<td>- Had to go without things.</td>
</tr>
<tr>
<td>- Bills weren’t paid.</td>
</tr>
<tr>
<td>- People had done things that could have got them in serious trouble.</td>
</tr>
<tr>
<td>• Gambling with:</td>
</tr>
<tr>
<td>- ‘Other’ people they know (ie not family or friends).</td>
</tr>
<tr>
<td>- People they don’t know (eg people online).</td>
</tr>
<tr>
<td>• Having more accepting attitudes towards gambling.</td>
</tr>
<tr>
<td>• Gambling on:</td>
</tr>
<tr>
<td>- Pub or club EGMs/casino EGMs or tables, TAB betting.</td>
</tr>
<tr>
<td>- the internet/mobile phone/0900 phone games.</td>
</tr>
<tr>
<td>• Drinking alcohol weekly or more often.</td>
</tr>
</tbody>
</table>
- Smoking cigarettes weekly or more often.
- Depression.
- Having attempted suicide (in the last 12 months).
- Poor wellbeing.
- Experiencing violence or bullying:
  - Witnessed violence in the home.
  - Been hit or physically harmed in their own home.
  - Has been bullied (weekly or more often).
- Truancy.
- Using the internet for 3+ hours per day.
- Playing computer games for 3+ hours per day.
- Demographic characteristics:
  - Maori, Pacific and Asian students.
  - Refugee background.
  - Sex- being male.
- Socioeconomic status- living in neighbourhoods with higher levels of socioeconomic deprivation.

### Teenage problem gambling: culturally competent assessment and intervention

(Tse et al., 2004)

- **Engage the client:**
  - When working with Asian youth, explore the meaning of gambling in their home culture. This approach removes personal blame or stigma.
  - Match the therapist: Where possible it is helpful to have a gender and culture match between the client and therapist.
  - The counsellor’s self-disclosure of their struggle to adjust to a new culture will communicate empathy to the client.

- **It is important to explain counselling confidentiality to the client** (and adherence to the code of ethics).

- **It may be necessary to use an interpreter.** There are several strategies which make this successful: (a) involve them as part of the treatment team; (b) inform the client about the interpreter’s name and seek the client’s permission before the interpreter arrives; (c) require the interpreter to sign a confidentiality agreement before meeting the client, and clarify the interpreting expectations with the interpreter

- **Identify the presenting problems:** In addition to assessing the extent and severity of gambling-related problems (eg type and frequency of gambling, amounts of money lost), a thorough assessment should cover: potential harm to oneself, family and property; and risk from other psychiatric or medical conditions, such as depression, the use of illicit drugs, and excessive consumption of alcohol

- **Problem gambling is often just the ‘tip of the iceberg.’** It is important to inquire about all the types of problems and challenges faced by Asian youth, including financial hardship, language barriers, and intergenerational conflicts.
Teenage problem gambling: culturally competent assessment and intervention
(Tse et al., 2004)

- **Asian groups from refugee backgrounds** have suffered from civil unrest, political persecution, or war, and the loss of family and community. Mental health disorders such as posttraumatic stress disorder (PTSD), depression and anxiety should be identified by the therapist. For some, gambling and other addictions provide an escape from pre-migration traumas.

- **During counselling, it is important to identify the strengths and resources** that the client (and potentially their family) can contribute to the effective management of their gambling problem. This may help the young person improve their self-esteem and sense of control.

- **Cultural/religious beliefs may assist with this process.** Therapists should find out about the client’s hopes for themselves and for their families. It is also useful to ask how the client coped with adversity before coming to New Zealand (i.e., what works for them).

- **Metaphor can offer a powerful therapeutic tool for counselling.** Appropriate use of metaphor may prompt Asian clients to reconnect with their cultural traditions. Using familiar images or folk stories may help clients gain a better understanding of their problem gambling and help them focus on recovery.¹

- **Identify whether support systems are in place** for Asian young people and to build up extra support or resources if necessary.

- **Help the young person navigate the services they need to access:** Crucial settlement issues are English proficiency, educational achievement and developing support systems. Counsellors/therapists need to make special efforts to ensure that clients know where to go for help, and that they will be referred to a culturally competent service provider (e.g., legal services; settlement support etc).

- **Power-distance:** Asian clients may have a different expectation of the therapeutic alliance. Asian clients are very conscious of social status and power. Therapists, counsellors, social workers, or other professionals are seen as people in authority. Clients may be uneasy if they are asked to work in partnership with the therapist. They tend to expect the therapist to take an authoritative position and to provide a 'quick fix.'

- **Practical approach:** Asian clients prefer a pragmatic, practical approach in dealing with

¹ For example, the cultural metaphor “山不转路转；路不转人转；人不转心转” illustrates the importance of ordering and the emphasis on multiple cultural values. This saying literally means if the mountain doesn’t turn the road turns, if the road doesn’t turn the person turns, if the person doesn’t turn then the heart and mind turns. Figuratively, it means that no matter how hard things get, there is always a solution. If you can’t find a way past the mountains (obstacle), then find a road around it. If there is no road around it, then make your own path. If you have done your best and still can’t change the situation or find a solution, then you need to change the way you think and feel about it. This type of saying can be incredibly healing, and could potentially be utilized in problem and solution-focused therapies (e.g., let's figure out how to solve the problem), mindfulness and acceptance-based therapies (e.g., it looks like we can’t change the other person or the situation, let’s figure out how to make the most of it and put our mind at peace), as well as cognitive-behavioral therapy (e.g., now that we tried to resolve the problem, what’s the most helpful and effective way to think about it) (Hwang, 2011).
### Teenage problem gambling: culturally competent assessment and intervention

(Tse et al., 2004)

Problem gambling. They usually welcome the idea of completing ‘homework’ or having a handbook to help them deal with problems in between appointments and to prepare for the next session.

- **Be directive:** Being directive means giving the client a limited number of informed choices, rather than leaving it entirely to the client.

- **Working with families:** It is crucial for the counsellor/therapist to discuss with young people any family involvement (obtaining their agreement and protecting their privacy). It is important to run separate sessions for family members in the initial phase of family intervention. If this is not done, the session can be chaotic, humiliating, and superficial and may be dominated by senior family members. When the young person’s parents are involved in counselling, it is particularly important to assure the client that the counsellor will not disclose their details to their parents. Typically in Asian cultures, parents assume the right to know everything about their children.
Internet game addiction (IGA) is an increasing problem in adolescents in Asian countries, which have wide access to the internet (Lee, 2011). The definition of Internet game addiction varies. DSM-V defines Internet addiction as: 1) excessive use, often associated with a loss of sense of time or a neglect of basic drives; 2) withdrawal, with feelings of anger, tension, and/or depression when the computer is inaccessible; 3) tolerance, with the need for better computer equipment, more software, or more hours of use; and 4) negative repercussions, with arguments, lying, poor achievement, social isolation, and fatigue (American Journal of Psychiatry, 2008). The prevalence of Internet addiction in the United States is from 0.3% in the general population (Shaw & Black, 2008) to 25% in undergraduate students (Fortson, Scotti, Chen, Malone, & Del Ben, 2007). Internet game addiction has negative effects such as loss of interpersonal relationships, failure to address responsibilities, distraction from other aspects of life, and poor health (Steward, 2004).

Related factors of game addiction include hostility (Chiu, Lee, & Huang, 2004), little or no self-confidence (Griffiths, 2000), depression (LaRose, Lin, & Eastin, 2003), loneliness (Nalwa & Anand, 2003), low self-esteem, stress, impulsiveness (Cho & Lee, 2004), and low self-control (Song, 1998). Interventions for Internet game addiction include value facilitation programmes (Jang, 2005), cognitive-behavioural therapy to increase self control (Lee, 2005), a self-growth programme (Oh, 2004), self-control training (Kim, 2004), and a game desire control programme (Pyo, 2003).

A treatment model which combines cognitive-behavioural therapy (CBT), behaviour modification, and a 12-step programme shows some success in treating internet game addiction in Asian adolescents (Lee, 2011).

The subject in this case study was a 16-year-old Korean adolescent who migrated to New Zealand. This case suggests that these 3 therapies could be combined to form a treatment model, which could significantly benefit the client and positively impact behaviour change (Lee, 2011). The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.
**Case Study 4: Internet game addiction (Korean)**
(Adapted from Lee, 2011).

Jin Soo, a 16-year-old Korean adolescent was referred to Child and Adolescent Mental Health Service (CAMHS) by his mother because of his negative attitude, depression, and overuse of the internet. Even though he did not want to emigrate from Korea to a Western country to study, his parents persuaded him to move with his mother and brother. He migrated to New Zealand 4 years ago and had difficulty speaking English. He withdrew from his friends. Jin Soo started playing internet games at the age of seven. Since moving to New Zealand, he spends many more hours playing games because he spends so much time alone.

For Koreans respect between older and younger generations is very important. While Westerners refer to another as “you” regardless of age and status, Koreans use different pronouns to address those who are older which indicate respect. Jin Soo has poor social relationships with his brother and with Korean seniors because he does not use the respectful forms of address. Jin Soo’s mother was concerned about his negative attitude towards his father. For example, when his father visited him from Korea, and suggested doing something together, Jin Soo was negative.

Jin Soo wanted to reduce the hours of using internet games. He spent 3 to 5 hours on playing games on weekdays and 13 hours on weekends. He said that it was difficult to control, especially on weekends.

**THE PROCESS OF INTERVENTION**
The counsellor was a European woman. Counselling consisted of five individual sessions that ranged in length from 30 minutes to 1 hour per week. Homework assignments were used to record Jin Soo’s activities and how he spent his time. The counsellor explored the thoughts, emotions, and behaviour that helped him to control his desire to play games. The counsellor and Jin Soo discussed how to manage his time during the week and stickers were used as a reward when he kept his promise.

**Behaviour Modification**
The first session focused on obtaining a general assessment. The second session focused on the assessment of game addiction and creating a contract for behaviour modification. Jin Soo agreed to try to reduce the time spent on games and to increase the time spent on other healthy activities. His mother promised to give him half the money he needed for a new computer if he reached his goal.
The contract was in written form and signed by Jin Soo, his mother, and a counsellor. Also, Jin Soo was asked to record the time he spent on games and alternative activities on paper. In the third session, his mother said that he had decreased his game-playing time but showed agitation because of reducing the time spent on games. He spent less than 1 hour per a day on weekdays, but spent over 3 hours per day during the weekend. He had little to occupy himself on weekends. He tried to talk with his mother and watched television dramas instead of playing games. In the fourth session, he reached his goal for only 2 days. He said that he woke up early, did homework, fared well in his exam, and exercised. He skipped two sessions because he slept late in the morning. His mother said that he sat up all night hanging out with his friends. In the fifth session, he did not reach his goal for even 1 day. He spent over 3 hours on games every day, but he tried to spend time on basketball, talking, and bowling with friends. He explained that he did not come the last 2 weeks because he thought it was too much trouble and it was too far to travel to CAMHS. When he was asked whether he wanted to continue with counselling, Jin Soo avoided giving a direct answer. He was given 1 week to think about this. After contacting the counsellor, finally he said that he wanted to give up.

**Cognitive-Behavioural Therapy**

Jin Soo was encouraged to be conscious that he was spending more time on games, than he intended to and to explain which emotions, thoughts, and behaviours contributed to his overuse of games. He was encouraged to think about which factors were helpful in reducing time spent on games. Jin Soo was asked to record his thoughts, emotions, and behaviours related to games on a form each week. In the second session, discussion focused on the reasons for spending time on games, the disadvantages of playing games, methods to use to decrease time spent on games, and how to improve his overall health. Jin Soo said he played online games because it was fun; he could meet people through online games, and feel satisfaction when he reached the goals of game scores. He wanted to reduce time on computer games because it interfered with his study and was not good for his health. In the third session, a screening tool for measuring his game addiction was given because he did not accept that he was addicted to computer games. He thought that if he wanted to, he could stop. He was encouraged to express emotions, thoughts, and behaviours related to games. He always felt bored at home. When he felt bored, he usually played computer games. He could not drive. His mother and brother were usually away from home until the evening or late at night and he was often alone on weekdays. Loneliness contributed to his game addiction. In the fourth session, he forgot to bring his homework. He expressed feeling burdened by doing his counselling homework. The idea of cognitive-behavioural therapy was good, but it was difficult for him to practice daily. As time went by, he had difficulty accurately writing down his exact hours on different activities. Additionally, he was asked to record weekly (1) his activities and time, (2) his emotions, thoughts, and behaviours related to games. It was difficult for him to keep the records and bring them to the sessions. The main issue for Jin Soo was managing his boredom. It was suggested that he do
something different with his time. After the fifth session, he started to learn golf and he was becoming more interested in golfing. This meant that he reduced the time he spent on games. He and his mother were encouraged to spend time outside the house doing something together such as playing golf.

**12-Step Programme**

The questions for each session were based on the 12-step programme (On-line game anonymous, 2006). For example, the goal of the first session was “we admitted we were powerless over on-line gaming and that our lives have become unmanageable”. The counsellor offered three questions to approach this goal. “Which part is difficult for you to control?”, “Which part is easy for you to control?” and “Have you despaired about your failure of self-control?” Jin Soo doubted the existence of God because he prayed for something but God did not answer. Therefore he doubted God could help with his problems. He did not feel the need to pray. In the fourth session, what harm he caused to others was discussed. He said that he often lied in online games to sell his items at a high price. He said that he used abusive words because his friend used those words. He said he would try to reduce the abusive words he used. He was encouraged to apologise to the people he harmed through lying and using abusive words. In the fifth session, demerits in his character were discussed. He said that he had difficulty accepting authority figures, often used abusive language, had perfectionism, and played games excessively. He thought that his perfectionism contributed to game addiction because he made a goal for game scores and he wanted to reach the goal. He was encouraged to think about the reasons he had difficulty having relationships with older people. He knew that he should use respectful language and manners when he met Koreans but he said that he did not want to behave differently towards Westerners and Koreans. It felt to him like having a dual personality. His counsellor empathised with the difficulty of living with the expectations of two cultures. He was encouraged to think about other’s perspectives. To have a good relationship with others, his counsellor explained the need to act differently according to different cultural norms.

**Result of the intervention**

The programme consisted of eight sessions originally. However, the counselling stopped after five sessions. During the counselling, there was some improvement. However, Jin Soo did not do his homework and did not keep his promise to reduce game hours. In the 2-month follow-up, his mother said that he had reduced his game time since he had started golfing with her.

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**Question 1:** Was this a culturally appropriate intervention?
**Question 2:** What could the therapist have done differently to keep Jin Soo engaged in counselling?
**Question 3:** How could Jin Soo’s parents have been engaged in the intervention?

*Discussion notes are available under the “Case studies-discussion notes” section.*
**Drug and alcohol abuse**

International literature indicates that when culturally appropriate Alcohol and Other Drug (AOD) services are available, service utilisation tends to increase in Asian communities (Fong & Tsuang, 2007; SAMHSA, 2014a; 2014b; Yu et al., 2009). Studies have demonstrated that treatment utilisation by Asian Americans increases substantially when bilingual and culturally appropriate staff provide the treatment services (Zane & Kim, 1994). Yu et al. (2009) found that generic early intervention models can be successfully adapted for Asian American communities. When culturally competent services combined with case management and motivational interviewing is provided, there tends to be an increase in Asian clients' chances of accomplishing treatment goals.

Substance use disorders among Asian groups may be attributed to a number of social and cultural factors. Refugees from Southeast Asian countries have endured multiple traumas such as living in war-torn areas, being forced to witness the torture and deaths of loved ones, facing the dangers of escape from their homelands, coping with life in refugee camps, and adjusting to a foreign culture upon arrival in a resettlement country (Amodeo, Robb, Peou, & Tran, 1996; Yee & Thu, 1987). Parents have high expectations of their children and may set very high and stringent standards for them. Young people who find a gap between what is expected of them and what they have actually achieved experience a high degree of emotional stress in their fear of failure, which they may try to relieve through use of alcohol and other drugs (Sekiya, 1989). In American studies, alcohol abuse is reported among Asian migrants for dealing with sadness and painful memories (D’Avanzo & Frye, 1992) but is also noted among acculturated Asian Americans as acculturation tends to lead to greater family and cultural conflicts with less assimilated parents (Bhattacharya, 1998). As a result, a significant number of Asian Americans, especially second-generation Asian migrants, turn to substance use as a way of escaping family confrontations and pressures (Mercado, 2000). The screening instruments used in Asian communities must be culturally appropriate and sensitive to the particular population (Naegle, NG, Barron, & Lai, 2002).

The table below explains **culturally responsive assessment and treatment planning for clients who present with alcohol and drug abuse** (SAMHSA, 2014b).

<table>
<thead>
<tr>
<th>Alcohol and drug abuse: Culturally responsive assessment and treatment planning (Adapted from SAMHSA, 2014b).</th>
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</thead>
<tbody>
<tr>
<td>The following nine steps are important to incorporate in drug and alcohol assessment and treatment planning processes to ensure culturally competent clinical and programmatic decisions and skills.</td>
</tr>
<tr>
<td><strong>Step 1: Engage clients.</strong></td>
</tr>
<tr>
<td>• Use culturally appropriate greetings and start with small talk—to begin building the</td>
</tr>
</tbody>
</table>
### Alcohol and drug abuse: Culturally responsive assessment and treatment planning

(Adapted from SAMHSA, 2014b).

<table>
<thead>
<tr>
<th>Therapeutic relationship.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Involve one’s whole being in a greeting—thought, body, attitude, and spirit.</td>
</tr>
<tr>
<td>• Aim to ensure that the client leaves the initial meeting feeling hopeful and understood.</td>
</tr>
<tr>
<td>• Try to establish rapport before launching into a series of questions.</td>
</tr>
<tr>
<td>• Draw attention to the presenting problem without probing too deeply.</td>
</tr>
<tr>
<td>• Ensure that the client feels engaged with any interpreter used in the intake process.</td>
</tr>
<tr>
<td>• Use culturally responsive interview behaviours.</td>
</tr>
</tbody>
</table>

**Step 2: Familiarise clients and their families with assessment and treatment processes.**

| • Remember that clients are typically new to treatment language or jargon, programme expectations and schedules, and the intake and treatment process. |
| • Educate clients and their families about treatment expectations. |
| • Walk clients through the treatment process, starting with the goals of the initial intake and interview. |

**Step 3: Endorse collaboration in interviews, assessments, and treatment planning.**

| • Take time to familiarise clients with the intake, interview, assessment, and treatment planning processes and how they can participate in these processes. |
| • Use a collaborative approach in the initial interview and assessment to discuss the expectations of both therapist and client. |
| • Establish ways for the client to seek clarification of his or her assessment results. |
| • Encourage collaboration by emphasising the importance of client input and interpretation. |
| • Use client feedback to help interpret results and identify cultural issues that may affect intake and assessment. |
| • Extend collaboration to client preferences regarding inclusion of family and community members in assessment and treatment planning. |

**Step 4: Integrate culturally relevant information and themes**

| • Explore culturally relevant themes to more fully understand clients and identify their cultural strengths and challenges. Themes include: |
| • Immigration history. |
| • Cultural identity and acculturation. |
| • Membership in a subculture. |
| • Beliefs about health, healing, help-seeking, and substance use. |
| • Trauma and loss. |

**Step 5: Gather culturally relevant information**

| • Obtain supplemental information, with the client’s permission, from sources other than the client (eg, family members, medical and court records, probation and parole officers, |
Alcohol and drug abuse: Culturally responsive assessment and treatment planning  
(Adapted from SAMHSA, 2014b).

- Obtain culturally relevant information from the family (e.g., religious beliefs, cultural practices that shape the client’s cultural identity and understanding of the world).
- Engage families early in the treatment process and be especially sensitive to the cultural background of family members providing cultural information.

Step 6: Select culturally appropriate screening and assessment tools
- Explore the availability of mental health and alcohol and drug use screening and assessment tools that have been translated into or adapted for other languages and have been validated for that particular population group.
- Consider instruments’ cultural applicability to the client being served (e.g., a screening instrument that asks the respondent about his or her guilt about drinking could be ineffective for members of cultural, ethnic, or religious groups that prohibit consumption of alcohol).
- Keep in mind the fact that research is limited on the cross-cultural applicability of specific test items or questions, diagnostic criteria, and psychologically oriented concepts in evaluative and diagnostic processes.

Step 7: Determine readiness and motivation for change
- Clients enter treatment programmes at different levels of readiness for change; these different levels require different approaches.
- Motivational interviewing can help therapists prepare culturally diverse clients to change their behaviour and keep them engaged in treatment (Miller & Rollnick, 2013).

Stages of change
- To understand motivational interviewing, it is first necessary to examine the process of change that is involved in recovery. The transtheoretical model of change—which is applicable to culturally diverse populations—divides the change process into several stages (Prochaska & DiClemente, 1984):
  - Precontemplation. The individual does not see a need to change. For example, a person at this stage who misuses substances does not see any need to alter use, denies that there is a problem, or blames the problem on other people or circumstances.
  - Contemplation. The person becomes aware of a problem but is ambivalent about the course of action. For instance, a person struggling with depression recognises that the depression has affected his or her life and thinks about getting help but remains ambivalent about how to do this.
  - Preparation. The individual has determined that the consequences of his or her behaviour are too great and that change is necessary. Preparation includes small steps toward making specific changes. For example, the client may have begun experimenting with possible change approaches such as going to an Alcoholics Anonymous (AA) meeting or stopping substance use for a few days.
Alcohol and drug abuse: Culturally responsive assessment and treatment planning

(Adapted from SAMHSA, 2014b).

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Action.</strong></td>
<td>The individual has a specific plan for change and begins to pursue it. In relation to substance misuse, the individual may make an appointment for a drug and alcohol assessment prior to becoming abstinent.</td>
</tr>
<tr>
<td><strong>Maintenance.</strong></td>
<td>The person continues to engage in behaviours that support his or her decision. For example, an individual with bipolar I disorder follows a daily relapse prevention plan that helps him or her assess warning signs of a manic episode and reminds him or her of the importance of engaging in help-seeking behaviours to minimise the severity of an episode.</td>
</tr>
</tbody>
</table>

Progress through the stages is:
- Nonlinear, with movement back and forth among the stages at different rates.
- Not a one-time process, but rather a series of trials and errors that eventually translates to successful change.

**Motivational Interviewing** (Miller & Rollnick, 2013).
- Motivational interventions assess a person’s stage of change and employ techniques likely to move the person forward in the sequence. Motivational interviewing is characterized by the strategic therapeutic activities of:
  - Expressing empathy.
  - Developing discrepancy.
  - Avoiding argument.
  - Rolling with resistance.
  - Supporting self-efficacy.
- The therapist’s major tools are engaging in reflective listening and soliciting change talk. This non-confrontational, client-centred approach to treatment differs significantly from traditional treatments in several ways, creating a more welcoming relationship.
- Be mindful of each client’s linguistic requirements and the availability of interpreters.
- Be flexible in designing treatment plans to meet client needs.
- Draw, when appropriate, upon the institutions and resources of clients’ cultural communities.
- Culturally responsive treatment planning is achieved through:
  - Active listening.
  - Making interpreters available when required.
  - Consideration of client values, beliefs, and expectations.
  - Incorporation of client health beliefs and treatment preferences in addressing specific presenting problems.
  - Referrals to appropriate traditional treatment resources to supplement clinical treatment activities (e.g., referral for acupuncture for Chinese clients).

**Step 8: Provide culturally responsive case management**

Case management:
- Provides a single professional contact through which clients gain access to a range of
Alcohol and drug abuse: Culturally responsive assessment and treatment planning
(Adapted from SAMHSA, 2014b).

- Helps identify the need for (and then helps coordinate) social, health, and other essential services for each client.
- Can be helpful during treatment and recovery for a person with limited English literacy and knowledge of the treatment system.
- Focuses on the needs of individual clients and their families and anticipates how those needs will be affected as treatment proceeds.

The case manager:
- Advocates for the client.
- Eases the way to effective treatment by assisting the client with critical aspects of life (e.g., food, child care, employment, housing, legal problems).

The case manager who cannot provide culturally or linguistically competent services himself or herself should:
- Provide an interpreter who communicates well in the client’s language and dialect and who is familiar with the vocabulary required to communicate effectively about sensitive subject matter.
- Build and maintain rich referral resources to meet the clients’ multiple needs.

Step 9: Incorporate cultural factors into treatment planning
Typically, programmes that provide culturally responsive services:
- Approach treatment goals holistically and include objectives to improve physical health and spiritual strength.
- Stress implementation of strength-based strategies that fortify cultural heritage, identity, and resiliency.

Operate on the premise that treatment planning is a dynamic process that evolves along with an understanding of client history and treatment needs.
Eating disorders

Many Asian countries report the rising incidence of eating disorders (EDs) (Gordon, 2001; Mond et al., 2010; Pike et al., 2011; Wan et al., 2003). The gap is closing between several Asian countries (such as: China, Korea, Taiwan, Japan, Singapore and Hong Kong) and the West with regards to both clinical pathology, as well as more widespread disordered eating, weight and shape concerns, and dieting behaviours (Lee et al., 2010; Mond et al., 2010; Pike et al., 2011; Pike & Dunne, 2015; Tsai, 2000; Wan et al., 2003). Even in Asian countries where EDs are believed to be less prevalent than in the West, comparative studies have emerged documenting eating attitudes and body dissatisfaction levels that are similar to or worse than those reported by individuals from Western countries (Kayano et al., 2008; Jung & Forbes, 2006; Jung et al., 2009; Jung et al., 2010; Tsai, 2000). A meta-analysis of 35 published studies showed that eating disorders have the highest rate of mortality of any mental illness, with a weighted annual mortality rate of 5 per 1,000 person-years (Arcelus, Mitchell, Wales, & Nielsen, 2011).

Eating disorders among Asian women have been hypothesized as a way for women to express distress without risking the family’s loss of face (Yokoyama, 2007) or violating the norm of emotional restraint (Jackson, Keel & Lee, 2006). Ting and Hwang (2007) assert that intergenerational cultural strain can lead to fundamental misunderstandings about love and care, as when parents use culturally normative child-rearing practices such as criticism and shaming with more acculturated daughters. Criticism applied to achievement, often culturally normative, may include focus on weight and appearance as well. Collectivist values may lead some women to try to achieve status and honour for the family through extraordinary measures (Hall, 1995; Smart, 2009).

Chng and Fassnacht (2015) explored the relationships between different categories of parental comments, body dissatisfaction, and disordered eating concerns in young men and women in Singapore. The study found that negative maternal comments emerged as a consistent predictor of body dissatisfaction and disordered eating for both genders (Chng & Fassnacht, 2015). The findings indicate that there are potential differences in Western and Asian parental influences on eating disorders. Asian mothers seem more influential than Asian fathers, a discrepancy that is greater in Asian than Western cultures.

Sue and Sue (2003, p.342) encourage therapists working with Asian clients to use “problem-focused, time-limited approaches that have been modified to incorporate possible cultural factors”. CBT is considered to be consistent with many Asian cultural values due to its educational, unambiguous, and solution-focused style (Hall & Eap, 2007). The deliberate emphasis on collaborative action, combined with a relative lack of emphasis on the past or family has made CBT acceptable to Asian clients and families who consider emotional
problems to be highly stigmatising and prefer treatment to be practical and non-invasive (Smart, 2009).

**Family Based Therapy: The Maudsley Model**

The Maudsley model of family therapy for children and adolescents with anorexia nervosa, integrates principles and skills from a variety of models (Dare, 1985; Lock et al., 2001). The Maudsley model is of prime importance because of its non-pathologising approach to families, because its techniques have been published in sufficient detail for standardised application by clinicians, and because of its strong history of empirical support (Rhodes, 2003). This model integrates principles and skills from many of the major schools in family therapy and is suitable for adolescents where there is less than three years duration of anorexia nervosa. It has been shown to be suitable for clients and families from CALD backgrounds (Rhodes, 2003).

The Maudsley model aims to break cycles of parental guilt and resulting criticism of their child. The anorexia (rather than any family members) is personified as the oppressor, and its influence on the family is mapped. Parental guilt can be perceived as another ‘trick’ of the anorexia. The parents can then be freer to take charge of the anorexia in the relative absence of criticism of the child. Very firm and insistent stands can be taken while maintaining the adolescent’s need for autonomy. Parents are encouraged to rely on their own expertise regarding refeeding techniques and reaching goal weights and are therefore a resource for the patients’ recovery rather than the cause of the illness.

**Engaging the family**

- This first meeting is of crucial importance in engaging with CALD families. It is important for clinicians/therapists to establish their roles and credentials. It may take 3-4 sessions to establish trust and rapport with the family.
- It will be helpful, where possible to use culture/language matched clinicians and therapists.
- It is important to establish who the family decision-maker, and care-taker/s are and to ensure that they are informed and consulted.
- Adopting a directive approach towards mobilising the parents’ sense of responsibility for refeeding their child will be more culturally acceptable.
- Where English is a second language, the use of a (preferably mental health trained) professional interpreter is important. Written communication may need to be translated. Be aware that the gender of and choice of interpreter may be important for families.

**Psychoeducation:**

- The first step is to employ circular questions to explore the effects of ‘the anorexia’. Family members can be encouraged to argue against the parent-blaming view that is held by the illness. The therapist also encourages the family to separate the patient from
the illness by stressing how little control the patient has over these behaviours, and how it has gradually overtaken her.

- Features of anorexia, such as distorted concepts of body image, food-related anxiety, and water-loading before weigh-ins may also be framed as ‘tricks that the anorexia has gradually employed’ to take control of the patient.
- The technique of collapsing time (White, 1986) is then used to create an intense scene regarding the possible medical effects of prolonged illness. This is an important focus, given that anorexia has the highest mortality rate of any psychiatric illness at 6–15% (Steinhausen et al., 1991; 1993). There are also risks of permanent growth retardation, osteoporosis, cardiac dysfunction, and structural abnormalities in the brain (Fischer et al., 1995).
- The parents are then encouraged to take two weeks off work to start the refeeding process and the adolescent is asked to take two weeks off school. The message the parents are left with can be summarised as ‘It is definitely not your fault, but it must be your responsibility’.
- It is helpful to normalise intergenerational conflict between young people and parents as a common experience in migrant families, as parents/grandparents may feel that they alone are encountering these issues.

**Cognitive Behaviour Therapy (CBT)**

Cognitive Behaviour Therapy (CBT) is a useful approach to psychosocial interventions with Asian clients if adaptations are made (Smart, 2009). Hall and Eap (2007) suggest that, within clinical reason, therapists resist confronting clients’ views about the aetiology of their problems and work cooperatively with them instead. It is helpful for therapists to pay attention to mind-body connections, possibly incorporating mindfulness practices (Hall & Eap, 2007). Therapists can respect the role of somatic symptoms and work to alleviate them (avoiding the tendency to dismiss somatisation as an inability to feel). It is better to work with face-saving values rather than to try and change them. Self-disclosure in the privacy of therapy for example, can be reframed as a way to solve problems, help preserve harmony in the family, and reduce the potential for problems to escalate (Hall & Eap, 2007). Ting and Hwang (2007) advise that in regard to treatment for eating disorders, therapists, when appropriate, reframe family struggles in the context of acculturation difficulties. While recognising that CBT may be the best approach to body dissatisfaction, therapists should include an exploration of how client distortions are impacted by devaluation of ethnic features in the broader society. Attention needs to be paid not only to weight but to dissatisfaction with particular body parts (Smart, 2009). The case studies offered encourage the use of empirically supported treatments (ESTs) for eating disorders (Wilson et al., 2007) and the provision of treatment that is sensitive to differences in culture (Cummins & Lehman, 2007; Yokoyama, 2007).
Cultural accommodation to the enhanced cognitive behavioural therapy model

Enhanced Cognitive Behavioural Therapy (CBT-E) is designed as a guide for individual therapy (Fairburn, 2008). Called transdiagnostic, CBT-E aims to benefit those with Eating Disorders (ED) who are appropriate for outpatient treatment (Smart, 2009). The enhancement to the model includes attention to mood intolerance, and three other clinical emphases are used when needed: clinical perfectionism, core low self-esteem, and interpersonal problems (Fairburn, 2008). The focus of treatment is to disrupt the factors that maintain the ED, such as helping the client to recognise cognitive biases (eg dichotomous thinking), as would be expected in a CBT plan (Fairburn et al., 2008b). In general, the model seeks to help clients try new behaviours and learn through mindfulness, balancing acceptance and change. The following case study with a Korean client uses a CBT-E approach, which is well suited to the client’s social and cultural situation and models a culturally competent approach to ED intervention.

The following case study illustrates the use of enhanced CBT in the treatment of a Korean adolescent girl with bulimia. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

Case Study 5: Bulimia (Korean)

(Adapted from Smart, 2009).

Jae Eun a 16 year old girl has reluctantly sought treatment with the ED clinic, saying that she is feeling hopeless about her weight. She has been binge eating a couple of times a week for over two years and has gained over 6 kgs over this time. She is distressed that her bingeing has increased and has begun vomiting in secret. In tears, she says “I have so much going for me and my whole family is upset that I can’t control myself”, “It’s not their fault though. They just want the best for me”.

Jae Eun is a 1.5 generation Korean who migrated from Korea with her parents as a one-year old. She is doing well at school and is top of her class in maths. Jae Eun plans to go to university and to major in Maths. Her parents run a successful Sushi café chain. Jae Eun considers herself a “Ko wi” (part Korean and part New Zealander). She tells the therapist that her parents are “more Korean and really conservative”.

Jae Eun attributes her body dissatisfaction to her first ever visit to Korea at age 14, saying that the girls and young women there were consumed with fashion and slimness. She is now considering getting eye surgery popular in Korea (to make her eyes rounder). She says that
she is “huge” compared to her Korean friends in New Zealand and in Korea, and even though she has excelled in nearly every other area, her parents are “concerned about her future”, which she says means that they are concerned about her finding the best possible husband. She says that she has an “athletic” build and that she enjoys sports and likes the feeling of strength in her body. However, she considers herself “bulky” and “unfeminine”. She says, “I’m a pretty girl and I’m ruining the whole package because I can’t control myself”. Jae Eun’s parents have agreed to therapy with the encouragement of their GP. Her mother tells friends that she is going for weight-loss treatment.

Some initial cultural considerations in using CBT-E in this case (Smart, 2009):

• The time-limited nature and solution-focused structure: likely to be acceptable to both the client and her parents.

• Inclusion of significant others: might be useful, but consideration must be given to issues of stigma and shame, as well as hierarchy in the family system.

• Approach to therapeutic relationship: empathic but authoritative qualities would likely be helpful, but dealing with the potential for premature termination may require cultural accommodation

• Personalised formulation of what maintains the ED: potentially less stigmatising than focusing on what caused the ED, but assessment is needed as to whether the linear rationale fits with Jae Eun’s belief system (and possibly with the family’s belief system). There is the need for awareness of how culture and gender influence the maintaining mechanisms.

• Examination of the overevaluation of shape and weight: will likely require attention to gender and culture (eg intergenerational cultural differences – See the Assessing Migrant and Refugee Children and Adolescents section) and possibly to internalised racism. Exploration is needed as to whether there is a connection between the need for eye surgery and ED

• Possible use of the expanded form of the treatment: would allow for more work with the cultural influences on perfectionism, self-esteem, and interpersonal relationships. (See Fairburn (2008; 2008a) for a full description of the treatment - http://www.credo-oxford.com/4.1.html).

Excerpts of the therapy process with the client

The therapist is a European woman in her early 40s. Following the initial assessment process, she meets with Jae Eun (who brings her older sister to this one meeting) to describe CBT-E. Jae Eun appears anxious about the strong behavioural focus of the first month. However, she understands the logic that binging and vomiting is not helping her to control her weight, and she agrees to “try anything”. He sister agrees to explain things to their parents. Jae Eun and the therapist work together on a tentative formulation of maintaining mechanisms related to her binging and purging. Jae Eun makes the following connections: (a) “I am letting down my family by being at this weight” and “I don’t like my eyes”
(overvaluation of weight and shape); (b) “Restricting makes me feel better temporarily but then I binge”; (c) “When I am criticised or don’t do well at something, I feel very guilty, which also makes me binge”; (d) Bingeing makes me want to vomit”; and (e) “Vomiting creates more guilt, and sometimes leads to more bingeing and restricting”.

• The therapist initially tries to encourage Jae Eun to rephrase the overvaluation of weight to reflect just her feelings, but suspects that she is missing the meaning of the client’s experience due to her own individualistic value system.

• Including the family in the formulation seems to be a necessary cultural accommodation, and the therapist works to understand that Jae Eun views her weight not as her own, but as a reflection on the family.

• Although Jae Eun readily grasps the logic of the formulation, looking at it presented in a written form upsets her and she cries. She feels very hurt by her mother’s frequent criticisms of her weight and she hates the comparisons made with her “perfect” sister. Jae Eun works hard to stop crying and is very embarrassed by her outburst. The therapist reflects gently how difficult the process is, and keeps in mind that cultural values of emotional restraint and protecting the family will be influencing Jae Eun’s responses.

• CBT-E attends carefully to the client’s ambivalence, and the therapist asks Jae Eun directly how she feels about the process of therapy. Jae Eun says “it’s fine” but will not elaborate. There is no indication of therapist self-disclosure in Fairburn’s (2008) text, but a cultural accommodation may be useful. The therapist says to Jae Eun: “You’ve mentioned the pressure from your family a number of times, as well as how much you love and value them, and I want to be sensitive to that as we proceed. I’m aware that we’re from different cultures, and we might have some different ideas about families and women’s roles based on that. It seems like it might also be hard to tell someone like me if there’s anything you don’t agree with or have questions about in the treatment”. Jae Eun responds with “No, it’s okay” at the time, later she stated that she appreciated the therapist’s effort.

• Jae Eun engages actively in learning regular eating and in doing the homework assigned. They go over Jae Eun’s reactions to the homework. Two adaptations to this exercise were made. The therapist makes an effort to learn about Korean food, which was mostly what Jae Eun ate at home and around which a number of her food battles occur. In addition, Jae Eun is asked to track the cultural dilemmas and influences that occur as she tries to follow the recommendations of the therapist. For example, Jae Eun feelsthat she cannot set limits on the amount of food her mother and relatives gave her. Although similar struggles occur for clients across cultures, the therapist realises that it is exceptionally hard for Jae Eun to challenge her parents, given traditional values of filial piety and hierarchy in the family. The therapist asks Jae Eun if she can bring her mother for a session or two, where she could provide some education about EDs and the treatment. But Jae Eun is sure that this would offend her parents and create more problems.

• As the first phase of treatment is ending, it is clear that this is not working optimally. Jae
Eun has altered some of her behaviours, and is externally compliant, but her mind set remains completely fixed. Her tears continue as do her statements that she is letting down the family. Jae Eun and the therapist go back through the formulation and talk about what barriers are keeping the treatment from working. Jae Eun finally states that she is very sensitive to her mother’s criticisms but has also become increasingly fearful of disappointing anyone, and believes that letting family and friends know who she really is or what she feels would be entirely unacceptable. She also admits that she wants to go out with a European guy she knows and that in future she wants some sexual experience before she gets married, but that such activities would have to be kept secret. To a significant degree, the function of ED within her cultural context appears to be a way for her to express and manage the distress of conflicting values.

- Together, Jae Eun and the therapist decide to add the interpersonal component to the treatment, believing that it will help increase self-esteem as well. Interpersonal Psychotherapy (IPT) is targeted to “grief, interpersonal role disputes, role transitions, and interpersonal role deficits” (Fairburn et al., 2008b, p. 217). In this case, the role disputes and transitions are adapted to address Jae Eun’s developmental stage, her emerging bicultural identity, and the interpersonal difficulties caused in part by the acculturation differences between herself and her parents.

- This represents a significant shift in the treatment, as the IPT module is a different therapy from CBT and is far less solution-focused. Sessions were lengthened, and one half was devoted to IPT and the other to CBT. The IPT module helps Jae Eun identify how certain relational patterns occur and contributes to her cycles of anger, guilt and shame. It permits a deeper discussion of how her bicultural identity puts her at odds with her parents at times and also leads to confusion about her role as a young woman. Jae Eun begins to reframe some of her mother’s critical comments: not accepting them, but understanding more about their intent and learning ways to defuse her reactions and conflicts. Although she is committed to honouring her family, she begins to question the utility of making physical appearance the only way that she can do that.

- Simultaneously, the CBT portion deepens and Jae Eun is able to explore how her thoughts about her weight and eyes are impacted by sexist and racist notions in Western society. In other words, her mind set begins to shift and the behavioural changes she has been adopting start to make more sense to her and take greater hold.

**Question 1:** How was this a culturally appropriate intervention?

**Question 2:** What may have led to a more effective family consultation?

**Question 3:** Which cultural accommodations were successful?

*Discussion notes are available under the “Case studies-discussion notes” section.*
The following case study illustrates the role of socio-cultural factors in the course of anorexia in a Chinese adolescent girl. The case study provides a question for viewers to consider and reflect on. *Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.*

**Case Study 6: Anorexia nervosa (Chinese)**
(Adapted from Rhodes, 2003)

Sally Wong is a thirteen year old girl admitted to hospital for the first time, with a weight of 32.9kg and a body mass index of 13.82. She was medically compromised with bradycardia (slow heart rate), hypothermia, and protein calorie malnutrition, including muscle wasting and poor peripheral blood flow. She was admitted for a total of eight weeks and commenced on overnight nasogastric feeds and a supervised menu plan during the day. She remained on bed rest for the first three weeks, and after five weeks graduated to supervised menu plan only. She attended the hospital school during her admission, as well as physiotherapy, and recreational group programmes. Family and individual meetings in the hospital were limited to diagnostic screening, psychoeducation, and general support. These in-patient meetings were not conducted by the therapist responsible for her outpatient family therapy. Sally’s discharge weight was 35.8kg. Sally’s family consists of her father, Winston, who works as a caretaker, her mother Leanne, who works parttime as a secretary, and her brother Michael, who is eight years old. The family is of mainland Chinese origin and immigrated to New Zealand thirteen years ago.

The therapist’s first contact with the family was by telephone. The therapist introduced himself and explained his role as helping them with Sally’s recovery once she was discharged from hospital. The family was then sent a short letter that reiterated points from the telephone conversation.

*Dear Mr and Mrs Wong,*
*It was good to speak with you yesterday on the telephone to make an appointment for our first family meeting to help you with Sally who is suffering from Anorexia Nervosa. I am particularly concerned about how she will progress once she is discharged from hospital and believe that you will be incredibly important in helping her to return to health. As we discussed, Anorexia Nervosa has the highest mortality rate of any psychiatric illness. We will all need to work extremely hard to make sure that she can recover.*
It is very important that every member of your family come to our meetings at the hospital. Each of you will have been affected by the anorexia and each of you will also have something important to offer, in standing up to the grip it has had on the family. It may be difficult at times for all of you to attend, but it is vital given how extremely vulnerable your daughter is at the moment.

I look forward to meeting you all at 1:00 in the Medical Centre. Could you please come fifteen minutes early so that our nurse can weigh Sally before we meet.

Yours sincerely,

The First Family Meeting

In the first family meeting, the parents described the effect that the anorexia had had on them since its onset six months ago. Both described how distressed they had been by her admission to hospital, but also expressed some relief due to feeling that they had not known how to help her at home. Winston was eager to point out that he felt Leanne was responsible for the severity of Sally’s illness because she had been less prepared to accept the illness than he. Further circular questions revealed that Winston’s criticism of his wife was also related to his own guilt regarding the illness.

Both parents were found to be united in blaming themselves and this was framed by the therapist as one of the anorexia’s manipulative tricks. Further questions were used to extend this process of externalisation to Sally. The anorexia was seen as more in control of Sally than vice versa. The anorexia was described as having been successful in deceiving her into seeing herself as fat, and also at getting her to drink water before her initial weighings at her General Practitioner’s surgery. No exercising was reported. Michael was observed to be actively involved in reporting on Sally’s behaviour, and Sally said that he often did this at home. Sally angrily stated that it had had a negative effect on their relationship. The therapist then summarised the session so far, taking great pains to empathise with the family’s suffering over the past six months.

The family was then asked what effect the anorexia would have on Sally if it continued to take charge over the next twelve months. Winston and Leanne described how her growth might be stunted and how her reproductive system might be damaged. The therapist described other possible medical complications as well as the risk that it could kill her. The family was visibly shocked by this, but the parents still stated that they would do whatever was possible to help her. The session was then summarised and the family was charged with the responsibility of standing up to the illness. The therapist expressed his firm belief that they were the best resource for this purpose. Arrangements were then made for the next session, the family meal.
The Family Meal
This session was held at 12.30 p.m. to coincide with lunchtime. Leanne brought ham sandwiches, fruit, and orange juice from home, and Winston brought a large serve of noodles and vegetables that he had purchased near his workplace. The parents were asked to attempt to get Sally to eat one more mouthful than she wanted to. Sally was also asked to resist their attempts so that they could gain some practice in taking charge of the illness. Michael was asked not to join his parents but to watch out for any signs of distress in Sally. During the early stages of the meal, the therapist asked the family questions about eating habits at home. Sally and Michael typically ate breakfast on their own, while Leanne made school lunches and Winston got ready for work. Winston was rarely present for dinner, but the remaining family members sat together. Sally was reported to eat the same food as the rest of the family, but in smaller quantities. Further questions, however, revealed that Sally often ate chicken when the others ate red meat.

Leanne had also taken to buying low fat milk and yoghurt instead of full fat dairy products. The parents were asked to consult their instincts about the kind and quantity of food that Sally would need to eat to gain a healthy weight. They both felt that she should be eating high fat dairy products and red meat, and should also be eating the same size servings as the rest of the family. At this point in the interview Sally had finished her sandwich and juice but stated that she did not want any fruit. Winston then proceeded to lean across Michael’s seat to ask Sally to try some noodles. The therapist asked Michael to move so that Winston and Leanne were sitting on either side of Sally. Winston was persistent in his requests, which was praised by the therapist. Sally became angry after the fourth request, telling him curtly to change seats again. The therapist then asked Michael to guess what effect his father’s attempts were having on Sally. He said she was angry because she would feel her father was hassling her. He also felt that she did not like being hassled in front of the therapist, whom she did not know very well. Sally agreed with these guesses and her anger seemed to settle. Winston and Leanne were then asked to continue standing up to the illness.

This process continued for twenty more minutes. On one occasion Leanne started to negotiate with Sally about the caloric content of the noodles. The therapist then asked Leanne if she had done this before and how effective it had been. She was encouraged to continue the monotonous requests with her husband. At 1.25 p.m. Sally asked the therapist if she had to eat a lot or only one taste. The therapist referred this question to the parents who indicated that she only had to have one mouthful. Sally then proceeded to eat this just in time for the end of the session. The family were congratulated on their success, but agreed that this process might be a lot harder at home. They agreed to eat their breakfast together, and Winston said that he would arrange with his work to be home for dinner two week nights per week.
Continued Focus on the Refeeding Process

The remainder of Phase I took nine weekly sessions. In this time Sally’s weight rose to 40.5kg, with no weight gain in the first two weeks and a decrease of 500g on week five. In the first two weeks, the parents had been successful in introducing high fat dairy products, but Sally had compensated by 30-minute daily periods of exercising in her room. The parents then agreed to stand up to this behaviour and developed a joint strategy of checking on her every five minutes when she was in her room. The therapist was careful to reinforce their success with dairy products, and their team approach to exercising. Michael had some difficulty forming an alliance with Sally in this first two-week period and was tempted on numerous occasions to join the parenting team in their refeeding task. Sally said this made her feel like everyone in the family was against her.

Winston and Leanne decided to help Michael by reminding him when he attempted to join them. From this point on, Winston and Leanne progressed well with the refeeding task. Michael also improved in his attempts to form an alliance with Sally. They had little success with getting Sally to eat red meat, but increased her intake of chicken and pork instead. They were gradually able to increase the amount of food she ate at each meal. Their main strategy was to insist monotonously, but they also developed more creative approaches. One strategy was to remind Sally how much she had disliked her stay in hospital. Another was to name anorexia ‘Annie’ and remind her jokingly when it was bossing her around. One two occasions Leanne became angry with Sally during refeeding when Winston was not home at dinnertime. Winston decided to call Leanne on the nights when he could not be home, to support her in the refeeding process. The family expressed some disappointment at week five when Sally lost 500g. The father requested that the therapist focus on telling his wife that she was responsible and stated that Leanne and Sally were both as stubborn as each other. He wondered if family relationships could be a focus of the therapy rather than simply concentrating on food. The therapist was very clear in pointing out the dangers of concentrating on issues that were not directly related to eating, given that Sally was still at serious medical risk. Further exploration of the events of this week revealed that Winston had worked very long hours due to the absence of his manager and that he had been quite critical of his wife upon his return home. This was again reframed as a product of his own concern for Sally, and as an attempt by the illness to split them up as a parenting team. The therapist revisited the collapsing time strategy from the first session, asking the parents about what might happen to Sally if the anorexia continued to be successful in this way. Careful plans were put in place to take back this ground from the illness. The father agreed to come home for dinner for the next week and both parents would follow strategies that had already worked in the past five weeks.

Phase II: Negotiating for a New Relationship

At week ten, the therapist and the parents decided to move to Phase II of treatment. The parents felt that Sally was well on her way to recovery, and expressed some relief that they
had been able to take charge of the illness. They both felt comfortable with gradually handing some responsibility back to Sally. A two-week experiment was set up for Sally to eat breakfast for two days per week without her mother or father present. Her parents also allowed her to go on a day trip with a group of girl friends and planned carefully which foods she would buy and eat. Within two weeks Sally had gained another 1kg and reported menstrual spotting. The parents also reported that they no longer needed to remind her to eat. The family was now eligible for the commencement of Phase III

Phase III: Adolescent Issues and Termination
The main adolescent concerns raised by Sally and her family involved conflict regarding Sally’s choice of social activities. Her parents were keen for her to become involved in a Chinese church and to join the youth group with other Chinese adolescents. Sally was more interested in socialising with adolescents from school from a variety of cultural backgrounds. The therapist was initially concerned that marital tensions might also be raised, due to Winston’s tendency to blame Leanne for the anorexia, but this was not the case. The therapist assumed that some degree of harmony between the couple had been achieved indirectly by the facilitation of a stronger parenting alliance. The parents and Sally were then asked to try and solve in the session the problem of Sally’s friends. They were encouraged to see this tension as a normal part of the life cycle for families from different cultural backgrounds and to find a win/win solution. Sally agreed to attend the church with her parents but not the youth group. The parents agreed to allow her to go out on the weekend with friends from school so long as they had met them beforehand. No further questions were raised. The family was seen on two more occasions over a twomonth period. The adolescent issue regarding Sally’s friends was resolved without the need for more intensive family therapy and Sally reached a weight of 41.9kg. Treatment was closed by asking the family to review their progress over the 21 weeks of treatment. The therapist expressed his confidence that they would succeed in the future if any problems arose and each family member was given an opportunity to say goodbye.

Question: What factors will need to be addressed in regards to successfully engaging with Sally’s parents over the course of the intervention?

Discussion notes are available under the “Case studies-discussion notes” section.
Post-traumatic stress disorder and children and adolescents from refugee backgrounds

Young people from refugee backgrounds are vulnerable to experiencing poor mental health. The experiences of forced migration, trauma, grief and loss, and resettlement can result in young people being particularly at risk of developing mental health problems (Colucci, et al., 2014; Centre for Multicultural Youth (CMY), 2015). Additionally, many parents from refugee backgrounds have undiagnosed mental health conditions due to their refugee experiences (CMY, 2015). Research indicates that young people from refugee backgrounds (CMY, 2014; 2015):

- Have a higher risk of depression, anxiety and PTSD than other populations of young people.
- Are at risk of social isolation, and poverty due to family financial pressures.
- Experience educational barriers due to a lack of or disrupted previous schooling.
- Have high levels of fear for family members left behind.

Colucci et al. (2014) suggest that there are higher rates of psychiatric disorders amongst young people from refugee backgrounds, compared with the adult population, although there are lower than expected numbers of young people from refugee backgrounds presenting to mental health services.

Refugee children and adolescents face the same issues of cultural adaptation and intergenerational conflict as migrant children do (Hyman, Vu & Beiser, 2000). They are also vulnerable to the effects of the refugee experience pre-migration, most notably exposure to violence, trauma and loss. Refugee groups who have had extended trauma experiences; as well as unaccompanied or separated children and adolescents, have higher psychological risk than others (Ministry of Health, 2012). A number of risk and protective factors either moderate or exacerbate poor psychological health including: family cohesion, parental psychological health, individual dispositional factors such as adaptability, temperament and positive self-esteem, and environmental factors such as peer and community support (Stevens & Vollebergh, 2008). Children are also vulnerable to the intergenerational transmission of trauma. Many refugee children and young people in the first and second generation experience mental health difficulties, including PTSD, depression, anxiety and grief (Weine, 2008). First- and second-generation children born to refugee parents with PTSD are more vulnerable themselves to PTSD and other psychiatric disorders (Weine, 2008).

Refugee children are often reluctant to discuss past traumas and choose to focus on the future. This should not be discouraged because a future-orientated view has been associated with lower rates of depression in refugees (Beiser & Hyman, 1997). Factors which
have been found to be protective in minimising psychological distress in children and young people are social and peer support from their ethnic communities, and the well-being of their parents (Weine, 2008).

The following table identifies the effects of trauma on children and young people from refugee backgrounds.

<table>
<thead>
<tr>
<th>The effects of trauma on children and young people</th>
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</thead>
<tbody>
<tr>
<td>(Ministry of Health, 2012)</td>
</tr>
<tr>
<td>There is growing evidence that children and adolescents experience a psychological reaction to trauma not dissimilar to that found in adults (Refugee Trauma Taskforce of the National Child Traumatic Stress Network (NCTSN), 2005). This may manifest itself in children in a number of ways including:</td>
</tr>
<tr>
<td>• Withdrawal, lack of interest and lethargy.</td>
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<tr>
<td>• Aggression, anger and poor temper control.</td>
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<td>• Tension and irritability.</td>
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<td>• Poor concentration.</td>
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<tr>
<td>• Repetitive thoughts about traumatic events.</td>
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<tr>
<td>• Physical symptoms such as poor appetite, overeating, breathing difficulties, pains and dizziness.</td>
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<tr>
<td>• Regressions (for example, return to bedwetting).</td>
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<tr>
<td>• Nightmares and disturbed sleep.</td>
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<tr>
<td>• Crying.</td>
</tr>
<tr>
<td>• Nervousness, fearfulness and proneness to startling.</td>
</tr>
<tr>
<td>• Poor relationships with other children and adults.</td>
</tr>
<tr>
<td>• Lack of trust in adults.</td>
</tr>
<tr>
<td>• Clinging, refusing to go to school.</td>
</tr>
<tr>
<td>• Hyperactivity and hyper-alertness.</td>
</tr>
<tr>
<td>• Repetitive, stereotypical play.</td>
</tr>
<tr>
<td>• Selective mutism.</td>
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</tbody>
</table>

Engaging with children and adolescents from refugee backgrounds and their families

The practitioner’s interest in learning about their client’s culture and religious background, and how the young person relates to their own cultural and religious identity is important (Valibhoy et al., 2015). It is important that professionals understand that young people from migrant and refugee backgrounds are often in the process of developing ‘multi-faceted identities’, “reflecting their exposure to varied environments and ways of life during their refugee or migrant journeys, at critical development stages” (Valibhoy et al. 2015).
Although ‘refugee’ can be a label many young people are keen to discard upon settlement in a new society, young people do want practitioners to understand some of the experiences they have faced, such as exposure to violence and persecution, and having to leave behind family and friends in dangerous environments (Valibhoy et al. 2015). Understanding the impact of their refugee experience is important, although the individual details of the trauma may not need to be discussed.

“A trauma centred approach acknowledges that the trauma is in the room, [the need to] work differently with youth with a trauma history, it’s not about having to talk about the trauma” (Colucci et al., 2015). Young people from refugee backgrounds value certain things from practitioners. This includes: advice, support and advocacy to address their needs as they see them, understanding the interrelationship of their practical problems and underlying psychological needs, and a holistic approach that integrates care for both their health and social wellbeing (Valibhoy et al., 2015).

Trust is central to how and whether young people from refugee backgrounds engage with mental health services. Establishing and building trust takes time; many young people have had their sense of trust in others eroded as a result of the refugee experience. Negative experiences with authorities during their migration journey can mean building trust with professionals is a slow process. Explaining how information collected will be used and ensuring confidentiality are integral parts of developing and maintaining trust (Colucci et al., 2015).

Additionally, using interpreters effectively is also important for young people from migrant and refugee backgrounds. Young people should be consulted at the point of referral about their interpreter preferences (for instance, do they prefer a particular gender, language or background?), as young people from small communities may have fears of confidentiality (Colucci et al., 2015). Using phone interpreters or employing bilingual health workers could also assist with ensuring confidentiality.

Using interpreters when necessary, particularly at the point of assessment, is important. This is a critical moment where both the young person and practitioner need to be able to effectively communicate and understand one another. For further information see CALD 4: How to work with interpreters (Waitemata DHB eCALD® services, 2014b).

Engaging with family and community is also an important aspect of supporting young people’s engagement with mental health services. Young people want mental health practitioners to understand the value of family to them and the way this may differ culturally from other client groups. It is important to seek the young person’s input as to if and how they would like a service to work with their family is important.
Advocacy, or holistically attending to the priorities of the young person should also be part of a mental health approach for young people from refugee backgrounds. Meeting young people’s practical needs builds trust and rapport, particularly if they are unfamiliar or hesitant to use mental health services. Best practice for refugee young people requires professionals who are not stuck in their own professional roles, and should work to address immediate needs, which might involve advocacy on the young person’s behalf (Colucci et al., 2015). It is important that mental health services have the flexibility to provide practical support and advocacy for young people and their families. This builds trust and addresses factors that may be compromising their mental wellbeing (CYM, 2015, pp. 7). Practical support may include assisting with family immigration, housing and income support issues.

**What sort of guidance can I offer to parents of children/young people experiencing a trauma reaction?**

- Ensure parents have the ability and willingness to support and guide their children and young people.
- Make use of appropriate services; for example, DHBs’ Child, Adolescent and Family Mental Health Services, RASNZ Centre (Auckland) and Refugee Trauma Recovery (Wellington).
- Consider advising parents to (Ministry of Health, 2012):
  - Encourage their children/young person to express their emotions.
  - Offer children/young person support while they are upset.
  - Ask their children questions to find out what they are thinking and imagining.
  - Reassure their children/young person about the future: the small details of their lives are important and need to be valued.
  - Encourage their children to be children – to play, explore, laugh and do usual things for their age.
  - Maintain routine and predictability, as this helps children/young people to believe that life is secure and predictable.
  - Set caring but definite limits: most children experiencing internal chaos will indicate their need to have clear boundaries set.
  - Minimise change and, when it is necessary, take time to prepare children/young people for it.
  - Give children/young people feedback about how they are going.
  - Avoid making this the time to correct any bad habits.
  - Avoid over-reacting to difficult behaviour as this may be the child/young person’s way of letting tension out.
  - Give the child/young person time to adjust to a new situation.
  - Make time for just being together (Gordon & Wraith, 1997).
The following case study illustrates a holistic approach to psychosocial intervention for PTSD in a child from a refugee background. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

Case Study 7: Post-traumatic stress disorder (PTSD) (Somali)
(Adapted from Ministry of Education, 2007).

Mohammed is a ten year old Somali boy from a refugee background who presents with severe outbursts of violent behaviour at school, and extended periods of isolation and withdrawal. Mohammed copes poorly with his anxiety about being away from his mother while at school. He abruptly leaves the classroom and calls his mother who collects him whenever he becomes anxious. Mohammed avoids school whenever possible, missing as many as 20 days a term. While at school, he is unsettled, attention seeking, aggressive with other children and unable to concentrate in the classroom. He is unable to form positive relationships with his peers. He is the only Somali child in his class. Mohammed is referred to the Child and Adolescent Mental Health Service (CAMHS) after a critical incident at the school, which is the latest of an on-going series of issues the school has experienced with this child.

Family history
Mohammed’s mother Zahra is a solo mother. Mohammed has a younger sister Deeqa who is eight years old. The family fled to a refugee camp in Kenya when Zahra’s husband was killed during the civil war. Zahra is using the parenting techniques which are used in Somali culture but these are ineffective in the New Zealand context. The children have no routines or boundaries and the discipline used to control them is ineffective. The family has a range of stressors which are impacting on Mohammed’s behaviour and his mental health including: living a long way from the school with no transport; having inadequate means of support and not enough clothing and bedding. Zahra is suffering from depression and posttraumatic stress disorder related to the family’s traumatic refugee experiences and to social isolation in New Zealand. Mohammed and his sister’s English is developing but their mother speaks very little English.

The Initial Engagement and Assessment
The CAMHS team’s initial process of engagement requires more time than it would usually take to build trust and rapport with the family. This happens with the assistance of a cultural adviser who speaks Somali. Zahra gives informed consent to proceed with an assessment and intervention. Engagement activities include:
• Talking to school staff (including teachers and counsellors).
- Observation of Mohammed at school and at home.
- Interviewing Mohammed, his mother and sister.
- Assessing mental health, trauma and other issues using standardised tests that are culturally appropriate for the context as well as discussions with family members.
- Consultation with CYFs regarding any care and protection issues.
- Multiagency meetings and review meetings to discuss the case.

### Analysis and Intervention Planning

In the assessment and analysis phase the following issues are considered for the child and the family:
- Predisposing factors eg past trauma.
- Precipitating factors eg antecedents/ existing stressors.
- Perpetuating factors eg reinforcing consequences.
- Preventative factors eg resilience, strengths, support systems.

Analysis of this information provides a framework for organising interventions. A coordinated, culturally appropriate/intersectoral intervention plan sets achievable goals for Mohammed and his family.

### Coordinated intervention plan

- It is evident that Zahra is not coping with the many ongoing stressors she faces. The social worker arranges respite care for her and arranges for the children to be placed with extended family in her community.
- The children are monitored both at school and in their temporary placement during this period.
- The CAMHS therapist works with an educational psychologist who coordinates a ‘managing difficult times’ strategy at Mohammed’s school to respond to his outbursts of violent behaviour.
- When Zahra improves she returns home and is provided with further support from the social worker.
- The family applies to Housing New Zealand for the family to be re-housed closer to the school, and accesses warm clothing and bedding for the family.
- An intervention plan to deal with the behavioural and mental health issues is then developed with Zahra and the children, addressing the most pressing issues first.

### Clarifying and Responding

- The clinical case worker introduces play therapy as a medium to help identify and reduce Mohammed’s anxiety. The clinical and education case workers collaboratively develop a number of coping interventions for him to deal more effectively with his anxiety in school and home environments. These include curriculum adaptation at school, techniques of positive visualisation and arousal reduction techniques.
- Mohammed is encouraged to delay contact with his mother until school break times rather than leaving the classroom mid-lesson.
• Mohammed has a number of one-to-one counselling sessions to begin working with his past trauma and his overwhelming feelings of anxiety.

Improving parenting skills
• The CAMHS and education case workers establish a behaviour modification programme to be run concurrently by Mohammed’s mother at home and by his teacher at school.
• In this programme, Mohammed is rewarded on a decreasing reinforcement regime to stay at school for an increasing number of days. Rewards include computer time in the classroom and a favourite weekend activity.
• Work with Zahra involves discussions to increase her understanding of her role in colluding with her son in his absences from school.
• Zahra is taught effective ways to manage Mohammed’s bedwetting and how to use more effective parenting methods. As a result of this, the bedwetting stops and bedtime and homework routines are established for both children. Zahra and the children report that they feel more rested and less stressed as a result of the changes.
• Both the education and CAMHS case workers undertake a series of family and one-to-one therapy sessions with the family to help them deal with the trauma they have previously experienced. As a result, Zahra and the children are better equipped to talk to each other about things that bother them. They report that they are starting to have conversations about real issues and are beginning to understand each other’s viewpoint better.

The School Context
• Mohammed’s school provides a school counsellor when he is feeling anxious and unsettled. The education case worker works with the staff to help them understand the issues faced by refugee families and how these might impact on Mohammed’s behaviour at school.
• The education case worker develops, in collaboration with the school, a specific social programme for Mohammed based on his skills and interests, to help his socialisation and to reduce his anxiety.
• As part of the intervention, a sports team is formed in which Mohammed plays a prominent role. This provides opportunities for him to improve his social standing with his peers as well as teaching him about team work, sharing and taking turns.
• The education case worker also works with Mohammed to improve his learning skills through exercises such as mnemonic techniques.

Positive Outcomes Identified
• As a result, the school reports that Mohammed’s absences have dramatically decreased to four days per term and that Mohammed is using the strategies to deal with his anxiety well.
• Mohammed reports that he is feeling less depressed.
• He is using his newly acquired academic techniques to improve his concentration at school and is more engaged with his schoolwork. Although Mohammed’s academic
results have not significantly improved, staff comment on how noticeably relaxed he now seems to be and his marked improvement in his command of English.

- As a result of his social programme, he excels at a sport, increases his confidence and develops better social skills. In using those skills, he makes friends at school and reports that he feels less isolated from his peers.
- Incidents where his behaviour is inappropriate decrease and school staff feel more positive about Mohammed.
- Zahra experiences more confidence in approaching the school about any problems. She also reports feeling less stressed and is motivated to attend English language classes for herself. This not only improves her language skills but also provides an opportunity for her to socialise and, as a result, she feels less isolated. She starts thinking about employment options. Her son’s behaviour has improved enough for her to venture out into her own community with the children without feeling embarrassed about their behaviour. She reports that this has made her feel more supported.

| Question 1: | What factors contributed to successful engagement with the family? |
| Question 2: | Why was a multi-agency collaborative approach to intervention important in this case? |
| Question 3: | How do the assessment and intervention processes for this case differ from other cases you work with? |
| Question 4: | How should the complex needs of refugee families and children be addressed in an ecological model? |

Discussion notes are available under the “Case studies-discussion notes” section.
Psychosis and schizophrenia

Immigration status is a risk factor for schizophrenia, other psychotic disorders, and bipolar disorders (Berg et al., 201). Elevated risk has been observed for ethnic groups and is highest for black minorities and immigrants experiencing greater cultural barriers (Adriaanse et al., 2014; Berg et al., 2011; DeVylder et al., 2016; DeVylder et al., 2013; Paksarian et al., 2016). Increased risk is equal for both first and second generation immigrants, and this finding has led to a growing consensus that the development of psychotic disorders in immigrants is associated with acculturation stressors (Berg et al., 2011). British, Dutch and Scandinavian studies have found that perceived discrimination is an important post-immigration stressor that is associated with heightened risk for psychosis (Adriaanse et al., 2014; Berg et al., 2011; DeVylder et al., 2016; Morgan et al., 2009; Paksarian et al., 2016). Minority status may result in overt discrimination and contribute to feelings of alienation from the majority culture. Discrimination is frequently measured as perceived, because confirming actual discrimination is difficult in a research setting.

Psychosis

The risk for psychotic disorders is increased for many ethnic minority groups and may develop in early childhood (Adriaanse et al., 2015). Children, who have psychotic experiences (PE), such as subclinical delusion and hallucinatory experiences, are at higher risk of developing psychotic disorders later in life. In a Dutch school–based study, more psychiatric problems, traumatic experiences and perceived discrimination were associated with the presence of psychotic experiences among ethnic minority youth (Adriaanse et al., 2015). Exposure to a high level of social adversity originating at a young age could explain the higher risk for psychosis among ethnic minorities (Veling et al., 2011).

The association between immigration and psychosis has been firmly established through more than twenty international studies and two meta-analyses, with an estimated relative risk of 2.1 to 2.7 for first generation immigrants relative to native-born populations (Cantor-Graae & Selten, 2005; DeVylder et al., 2013; Coid et al., 2008). Ethnic minorities are also at increased risk for psychosis if exposed to racism and discrimination in the community and workplace (Veling et al., 2007). Younger age at immigration is associated with greater duration of exposure and, consequently with an increased risk for psychosis.

Acculturative stress and psychotic-like experiences

DeVylder et al’s (2013) American study reports an association between acculturative stress and Psychotic-like Experiences (PLE) among a national community sample of first-generation Asian immigrants. Asian respondents who reported increasing numbers of acculturative stress items were at progressively greater risk for PLE (particularly visual and auditory hallucinations, but not delusions) in a dose–response fashion. Several studies have prospectively demonstrated the associations between daily stress and increased psychotic-like symptom severity among help-seeking youth at clinical risk for psychosis (DeVylder et
Acculturative stress may likewise consist primarily of the experience of persistent minor hassles (DeVylder et al., 2013). Increased sensitivity to ongoing stressors associated with adjustment and integration to a new culture, and the inability to effectively cope with these ongoing stressors, may contribute to the association between psychosis and immigration. Younger age at the time of immigration has been associated with increased risk of psychosis among non-western immigrants to the Netherlands (Veling et al., 2011). Risk for PLE for ethnic minority immigrants may be related to environmental factors, particularly those that occur or begin during childhood (e.g., perceived discrimination, childhood separation from parents), with risk increasing as duration of exposure increases (DeVylder et al., 2013).

**Social determinants of psychosis among immigrants**

Dutch studies have found that the incident rate for all psychotic disorders is highest among the ethnic groups who report the most severe discrimination (Eilbracht et al., 2015; Veling et al., 2007). Studies covering different psychotic disorders at different stages of development in different immigrant groups also indicate that high rates of discrimination may be associated with the onset- and/or symptomatic features of the psychotic disorders (Berg et al., 2011; Janssen et al., 2003). A number of studies suggest that immigrants and ethnic minority groups with psychosis have a distinct psychopathological profile compared to patients of the majority culture. There are reports of more hallucinations, primarily auditory, among psychotic patients from a number of ethnic minority and immigrant groups both in the USA and Europe (Berg et al., 2011; Vanheusden et al., 2008).

Perceived discrimination is also associated with the positive symptoms of delusional and paranoid ideation (Janssen et al., 2003). In addition, there are reports of more severe depressive symptoms among both ethnic minority and immigrant patients with psychotic disorders (Veling et al., 2007). These studies have demonstrated that patients from ethnic minority groups appear to exhibit more severe positive and affective symptoms across a broad range of psychotic disorders.

Berg et al. (2011) suggest that discrimination can be an important environmental stressor leading to the development and escalation of both depression/anxiety and positive psychotic symptoms in patients with psychotic disorders. This finding may help to explain the distinct psychopathology profiles reported in different ethnic minorities. The experience of social deprivation based on visible minority status may lead to feelings of hopelessness and an external locus of control, both of which are psychological mechanisms associated with depression. Visible minority status may also enhance alienation and in some cases lead to actual persecution. Cultural differences can result in miscommunication between the minority and majority populations. For individuals predisposed to psychosis, these experiences can lead to enhanced suspiciousness and to psychotic episodes. This conclusion is supported by findings demonstrating that peer victimisation in childhood increases the risk for psychotic symptoms, independent of prior psychopathology or family adversity.
(Schreier et al., 2009). It is possible that individuals who are prone to psychosis or suffering from paranoid ideation are likely to perceive neutral or ambiguous situations as discriminatory (Berg et al., 2011).

**Clinical Implications**

The primary clinical implication of an association between stress sensitivity and psychosis is that stress alleviation techniques may be beneficial for people with psychotic experiences (PE) (i.e., hallucination-like or delusion-like symptoms that do not meet diagnosable criteria due to insufficient intensity, persistence, or associated impairment) (DeVylder et al., 2016). Interventions that alleviate perceived stress may be efficacious in reducing symptom severity among individuals with psychotic disorders, or may be potentially efficacious in preventing or delaying psychotic disorder onset among help-seeking youth with sub-threshold psychosis (i.e., youth at clinical high-risk for psychotic disorder) (DeVylder et al., 2016). For example, mindfulness training has been shown to have moderate efficacy for people with psychotic disorders in a recent meta-analysis (Khoury et al., 2013). Physical exercise, which can reduce stress, has likewise been shown to alleviate psychotic symptoms in a meta-analytic study (Firth et al., 2015). Stress sensitivity can be directly addressed through psychotherapeutic approaches such as cognitive-behavioural therapy, which has shown to be efficacious in treating psychotic symptoms, even in individuals with schizophrenia who are not taking antipsychotic medications (Morrison et al., 2014). Stress alleviation is likewise a key component of attempts to prevent or delay the onset of schizophrenia in help-seeking youth at clinical high risk, among whom cognitive therapy and supportive therapy appear to be beneficial (Thompson et al., 2015).

Racial-ethnic minority or immigrant status is a consistent risk factor for schizophrenia in European and American studies (Adriaanse et al., 2014; Morgan et al., 2009; Pakserian et al., 2016; Vanheusden et al., 2008). Longitudinal studies have found that psychosis-like symptoms predict subsequent psychotic disorder in both adolescents (Zammit et al., 2013) and adults (Werbeloff et al., 2012).

The following case study describes the barriers for South Asian Muslim families to engagement with CAMHS. In South Asian communities mental illness is closely associated with madness and therefore highly stigmatised. Parents are concerned about associated gossip which would broadcast the stigma. Stigma arises from the heritability of madness, with the mother’s standing in her husband’s family as a potential carrier of madness and children’s marriage prospects jeopardised. Gossip about madness is a strong disincentive to any help-seeking beyond very close, trusted family. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.
Case Study 8: Psychosis (Muslim)
(Adapted from Bradby et al., 2007).

Rifat was 13 when first admitted to hospital hearing voices. At that time she ‘did not want any help’ and felt that ‘everybody was against me’, worrying that the hospital was ‘going to keep me over there for ever.’ During the first couple of years Rifat felt very suspicious of her medication, and, particularly when she felt well, she would stop taking it and subsequently symptoms would recur. Rifat says in the past she ‘went hyper’, got very withdrawn or ‘could not think’. She attempted suicide on at least two occasions, and was admitted to hospital as an emergency twice, once against her will, (under section) when legal powers were invoked to impose treatment. Rifat’s mother points out that Rifat is not mad, but does have an illness. Since the family had not met this type of illness before, they were extremely worried and sought help from the Molvi (holy man) at the mosque. Stories of possession by ghosts or djinns (which they now regard as foolish) frightened the family and they put prayers written on fragments of paper (taveez) around Rifat’s neck.

Now aged 16 and attending college, Rifat says she understands the importance of her medicine. Her clinicians describe her condition as stable and appropriately medicated. Rifat’s mother says her daughter is ‘fully recovered now’. Rifat’s mother makes no criticism of medical staff and their understanding of Rifat’s medical needs, but insists that hospital arrangements were deeply unsuitable for her daughter: Rifat was in a mixed psychiatric ward sleeping next to a young man. No special provision was made for her halal food requirements, toilet and hygiene habits or her prayer routine, which as an observant Muslim were important elements of daily life.

Question 1: What factors are involved in Rifat’s late presentation for mental health care on her first and subsequent admission to hospital?

Question 2: How could the staff caring for Rifat in the inpatient setting have made her care culturally and religiously acceptable to Rifat and her family?

Question 2: How will psycho-education help when explaining Rifat’s illness to her and to her family?

Discussion notes are available under the “Case studies-discussion notes” section.
Schizophrenia

Immigrants and their descendants are, on average, 2.5 times more likely to have a psychotic disorder than the majority ethnic group in a given setting although the exact risk varies by ethnicity and setting (Cantor-Graae & Selten, 2005; Hollander et al., 2016). For example, in Europe, incidence rates for people of African descent are approximately five times higher than those for white European populations (Hollander et al., 2016). These marked differences, which persist after adjustment for age, sex, and socioeconomic position, are maintained in the descendants of first generation migrants, and are not attributable to higher incidence rates in people’s country of origin (Borque et al., 2011). Explanations centre on various social determinants of health, including severe or repeated exposure to psychosocial adversities such as violence, trauma, abuse, socioeconomic disadvantage, discrimination, and social isolation.

In particular, refugees and asylum seekers face substantially elevated rates of schizophrenia and other non-affective psychoses, in addition to the array of mental, physical, and social inequalities that disproportionately affect these vulnerable populations (Hollander et al., 2016). In a number of studies, migrants and refugees from sub-Saharan Africa are at increased risk of having a psychotic disorder, compared with European–born groups (Bourque et al., 2011; Hollander et al., 2016). Clinicians in primary and secondary care settings need to take the early signs and symptoms of psychosis into account in refugee populations and intervene early.

There are marked differences in the diagnosis, symptoms, and treatment of schizophrenia in various ethnicities and cultures (Banerjee, 2012). Traditional societies are more likely to have social or supernatural explanatory models of mental health disorders.

Symptomatic Variance

Substantive research shows that basic schizophrenia symptoms such as hallucinations, anhedonia, antisocial behaviour, depressive symptoms, emotional processing, and mood induction, vary across cultures (Bae & Brekke, 2002; Bauer et al., 2011).

Diagnostic Variance

In Asian countries, for example, Japan, the exact meaning of the word schizophrenia translated means, “split-mind disease” (Kim & Berrios, 2001). This terminology is a very “powerful and stigmatizing” label in Japanese, Korean and Chinese cultures with serious implications for patients (Kim & Berrios, 2001). Psychiatrists in Asian societies are less likely to reveal a diagnosis of schizophrenia to family members and to patients (Kim & Berrios, 2001). Kim and Berrios (2001) found that in Japan, only 16.6% of patients knew their own diagnosis, and only 33.9% of their family members did (Kim & Berrios, 2001). In addition, psychiatrists often gave euphemistic diagnoses, such as “neurasthenia” or “autonomic nervous dysfunction” instead of the real diagnosis, making the prognosis and treatment
even more complicated. Kim and Berrios (2001) regarded this phenomenon as so serious and ingrained that they suggested a renaming of the disease in ideographic cultures to promote transparency and easier communication.

**Traditional Healing**

Peoples from Asian, Middle Eastern and African backgrounds may use traditional healers alongside western models of care. For example, among Southeast Asian groups, Vietnamese families might seek out Taoist teachers and ethnic health practitioners such as Vietnamese physicians, Cambodian and Lao families might use Buddhist monks (Versola-Russo, 2006). The use of traditional medicine has to do with belonging to a collective culture and strong ties to the extended family. When a person is ill, many of the family members are involved in deciding if the client is ill, the extent of the illness, the treatment to be given, and by whom (Versola-Russo, 2006). Rather than viewing traditional healing as a barrier, it should be viewed as a strength and resource. Showing an understanding of the role of traditional medicine helps clinicians to build rapport with the client and family. The use of herbs is common among Asian groups. However, this practice may interfere with the efficacy of psychotropic medications. Fundamental Asian health beliefs that may impact mental health treatment include imbalance of the yin and yang, and the corresponding conditions of “hot” and “cold”. Illness may be attributed to an upset in this balance of forces.

**Assessment and Treatment**

Kim, Bean, and Harper (2004) present eleven specific guidelines when working with Asian clients and families: Assess support systems; assess immigration history; establish professional credibility; provide role induction; facilitate “saving face”; accept somatic complaints; be present/problem focused; be directive; respect family structure; be non-confrontational; and provide positive reframes.

**Family Support**

Culture shapes the way in which families respond to schizophrenia. An understanding of a client's cultural heritage can improve the quality of the relationship between the mental health professional and client (Versola-Russo, 2006). Family education and ongoing support is beneficial in order to maximise the support the family network can provide the client. This is especially critical when the client is under the direct care of the family. The extended family is important, and any illness concerns the entire family. Mental health professionals should be mindful that decision-making varies with traditional family structures.

In Asian cultures, families generally do not institutionalise family members. They care for them in the home. Asian families are more likely to accompany the schizophrenic client on clinic visits and to actively participate in treatment decisions (Bae & Brekke, 2002). Collectivist cultures emphasise family integrity, harmonious relationships, and sociability. Bae and Brekke (2002) note the importance of incorporating cultural characteristics into the intervention process. Interventions that are designed to involve families in a collaborative
effort may be more appropriate for clients from CALD backgrounds because of the interdependent nature of collective family dynamics.

**Case Study 9: Misdiagnosis of schizophrenia (Arab family)**


The case of Omar, an adolescent from Iraq highlights the consequences of the clinician’s not being familiar with culturally normal behaviour and treating presenting symptoms according to the clinician’s own cultural norms. This leads to misdiagnosis and inappropriate treatment for Omar and his family. At the core of this case and at the heart of cross-cultural psychiatry is the question, "Is this behaviour normal?" (Budman, Lipson & Meleis, 1992). This question must determine normality in its cultural context. This case study can be requested free of charge from your DHB library service or academic provider.

**Brief background of the case**

Omar, a 17-year-old boy from Iraq, was referred to a child and adolescent psychiatric inpatient unit for evaluation of sleep and appetite disturbances, phobic behaviour, and social isolation. Omar's problems had begun three years earlier, before migration. During the war in Iraq, Omar became anxious and reluctant to attend school, and withdrew from his usual activities and friends. After the family's arrival, Omar's symptoms worsened. It was when Omar's school truancy became marked that he was referred by the school to a local CAMHS for assessment.

This case (1) describes Arab migrant and cultural issues that may influence psychiatric diagnosis and management, (2) demonstrates how a team that includes a cultural consultant can influence the diagnostic process and outcome of psychiatric care, and (3) describes components of the role of the cultural consultant in psychiatric care. Four issues are particularly relevant for understanding this case: understanding the refugee experience and the impact of resettlement; understanding adolescent development and identity in the Middle East, family relationships, and somatic expressions of various mental states.
Sexual identity issues

Research shows that sexual minorities are at greater risk for trauma exposure, mental health problems, and substance misuse (Balsam et al., 2015). Additionally, Asian youth who identify as LGBTQI (lesbian, gay, bisexual, transgender, queer, intersex) face marginalization as an ethnic minority and as a sexual minority, but also marginalisation of their sexual orientation because of their cultural identity and vice versa (Florida, 2014). Asian males and females who identify as LGBTQI face additional stressors compared to European counterparts stemming from Asian family and community cultural values (Kumashiro, 1999; Han, 2008; Chung, 2006). A defining feature of collective cultures is the importance of the extended family group, expectations of conformity, clear gender roles and maintaining family honour and shame (Greene, 1994). Along with filial piety, Asian males face a strong obligation to carry on the family name. As well, among the psychological and developmental stresses that face gay Asian and other ethnic minority youth is the level of homophobia in Asian communities (Green, 1994).

In Asian cultures, sexuality is a private matter. Asian gay males not only violate the cultural practice of privacy but also fail to comply with familial obligations to continue the family name (Greene, 1994). Because sexuality is a private matter, sexuality is not considered crucial to one’s identity. Mao et al. (2002) also posit that for many Asian cultures, what Westerners would describe as homosexual activity does not necessarily translate to a homosexual identity. For example, being intimate with someone of the same gender does not necessarily mean that you are homosexual. Another possible explanation is the way that language poses a problem. Many gay Asian youth find it very difficult to discuss their gay identity with parents who have a different vocabulary to talk about their young person’s emerging homosexuality (Poon, 2008).

A study of sexual orientation and sexual behaviour in Asian American sexual minorities reported higher levels of unfair treatment and psychological distress compared to their non-LGB-identified sexual minority counterparts, and unfair treatment was positively associated with psychological distress (Chae & Ayala, 2009).

Traditional categories of sexual orientation which have been developed in Western societies may be less culturally relevant among ethnic minority groups, for example there are no culturally equivalent words for gay in most Asian languages (Chae & Ayala, 2009).

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2 Unfair treatment was measured using nine items from the Everyday Experiences of Discrimination Scale developed by Williams, Yu, Jackson, and Anderson (1997), designed to measure routine experiences of unfair treatment: being treated with less courtesy, less respect, receiving poorer service, being perceived as less smart, dishonest, not as good as others, being feared, insulted, and harassed (Chae & Ayala, 2009).
Significantly, the adoption of a LGBTQI identity among Asian sexual minorities is associated with higher levels of psychological distress than mainstream populations. Asian LGB-identified sexual minorities have markedly higher levels of psychological distress compared to those who are non-LGB identified (Chae & Ayala, 2009). Notably, the mean psychological distress score for LGB-identified Asians in Chae and Ayala’s (2009) study fell within the 15 to 19 range. This range has previously been found to be associated with a 17.8 percent chance of meeting criteria for a DSM mental disorders versus those in the 10 to 14 range, which is associated with a 5.4% chance (Andrews & Slade, 2007). American–born Asian sexual minorities are more likely to report being LGB compared to those who were foreign born. Participants of Chinese ancestry are also more likely to identify as LGB compared to Asians of other ancestries. Asian men are also more likely to identify as LGB compared to women. This and other studies, suggest that discourses and constructions of sexuality among ethnic minorities and, in particular, populations that are predominantly foreign born may differ from mainstream conceptualisations (Chae & Ayala, 2009).

In contrast to “coming out” paradigms that suggest that the adoption of an LGBTQI identity may confer psychological benefits, studies suggest that identification as LGBTQI in Asian communities may be associated with greater exposure to unfair treatment that may negatively impact mental health (Chae & Ayala, 2009). Identification as LGB among Asian sexual minorities may also be associated with other social hazards such as rejection by family members, social isolation, and experiences of sexuality discrimination, which may also increase the risk of poor mental health (Chae & Ayala, 2009; Cochran et al., 2007; Kertzner et al., 2009). Studies of Asian LGB communities show that those who place greater importance on their sexual orientation in defining themselves exhibit higher levels of depression (Chae & Ayala, 2009; Chae & Yoshikawa, 2008). Asian Americans report being less “out” to family members in comparison to White sexual minority members. “Coming out”, in the context of Asian and other ethnic minority families is complicated. While keeping one’s sexual identity from family can add an additional stressor, keeping sexual orientation hidden from family members helps to maintain affiliations to broader ethnic communities and to support and buffer young people against racism. Experiences of racism and discrimination may lead to reluctance to risk experiencing rejection from family for one’s sexual orientation.
Suicide risk

Culture shapes people’s view of suicide. Different cultures understand suicide and suicidal thinking in different ways. In some cultures, there is a strong stigma attached to suicide and the families and carers associated with a suicidal person. This section explores aspects of suicide risk assessment particular to Asian youth. It presents the findings of Asian suicide studies in New Zealand, as well as approaches to Asian suicide risk assessment based on Asian cultural values. In this context, the issues of acculturation, the experiences of immigration, intergenerational relationships, collectivist cultural values and perfectionism, which are psychosocial commonalities across Asian groups, contribute to risk. Culturally informed considerations for suicide risk assessment and ways to manage related confidentiality issues are provided. The overarching goal is to promote sensitivity and an understanding of suicidal Asian youth in their social context and, to thereby enhance collaboration in the assessment process at the time of a suicidal crisis.

Asian suicide research in New Zealand

A study of suicide in Asian communities in New Zealand highlights youth as a vulnerable group for suicide risk (Ho, Au & Amerasinghe, 2015). Academic pressures, unrealistic parental expectations, parent-child conflicts and possible identity and sexuality crises, are noted as risk factors for Asian youth, with international students being mentioned as a high-risk group (Ho, Au & Amerasinghe, 2015). With regard to early intervention, informants suggested, in particular, the need to address underlying mental health issues at an early stage. Because of the stigma associated with mental illness in Asian communities, even where specialist mental health services are available, many Asian people with depression and related mental health conditions may choose to visit GPs where they are more likely to report physical complaints rather than psychiatric symptoms. General practitioners were believed to have a particularly important role to play in the recognition and treatment of vulnerable youth.

Academic pressures from family, which generated an intense fear of failure, were mentioned repeatedly by some informants, as a dominant factor influencing suicidal behaviours for Asian youth (Ho, Au & Amerasinghe, 2015). International students are a high-risk group as reduced social support and English language difficulties, in addition to academic pressures, can increase the risk of suicide. Concerns were voiced particularly for Chinese international students as they were likely to come from one-child families and therefore be the sole point of focus of parental pressures. During exam times, there is an increase in referrals of international students to CAMHS and it is recognised that this is a high-risk period for suicidal behaviours, as the outcomes of exams could determine their further stay in the country.
Unrealistic parental expectations were emphasised by the majority of informants as a major source of distress and low self-esteem for Asian youth in general. Examples of parent-child conflicts specified by two clinicians included both emotional and physical abuse, such as negative, invalidating comments, hitting and throwing objects when expected grades had not been achieved, as well as acting in an authoritative manner over their children’s career path. They proposed that Asian youth with such family backgrounds were more likely to have emotional dysregulation problems and to engage in self-harming behaviours, but they were not necessarily considered suicidal at this early stage (Ho, Au & Amerasinghe, 2015). A GP added that self-harming and suicidal behaviours for Asian youth tended to be unpredictable and impulsive, and that they were more likely to present at the Emergency Department (ED) than at the GP clinic. Young South Asian women had particularly high rates of presenting at ED for self-harming (Ho, Au & Amerasinghe, 2015).

There are hidden issues which are thought to elevate the risk of suicide for Asian youth. Mental health service providers indicate that clients are reluctant to disclose sexual identity issues and sexual abuse issues due to stigma, the fear of shaming and, repercussions from their families.Clinicians in the following interview stated that even clients they had engaged with for over a year, were unwilling to disclose these issues (Ho, Au & Amerasinghe, 2015, p. 38-39):

His parents had given up a lot to come here, for them to have better opportunities. Both parents were working two jobs. I think there was a lot of pressure on him academically ... Not only that, I think he started to decline academically, he was going through very severe identity crisis, he was disillusioned with what the church said - quite religious parents - and what science said. I think he was struggling and in all that stuff there was his sexuality and body dysmorphia and he just, ... [method of suicide withheld] ... And again we think that this was pre-meditated. His family weren't letting him out of their sight. And he described this kind of chronic, you know, thoughts of 'I'd rather be dead than deal with this.' ... we knew there was more going on but he just wouldn't tell us. Interestingly, because I saw him twice at home and on both occasions I asked his mum, 'Could we speak with him alone?' She refused to leave his room.

The internet has had an effect on Asian youth on the forming of suicide pacts and peer-influenced suicidal behaviours, as has the influence of emerging methods of suicide in Asian countries, such as hydrogen sulphur poisoning. The copycat effect has a considerable influence on youth suicidal behaviours.
The New Zealand Youth 2007 study found that mental health issues were a significant concern among Asian youth, especially among female students (Parackal, et al., 2011). Significant depressive symptoms were reported by 18% of females and 7-8% of male Chinese and Indian students in the study (N= 1,310 students, between 13 and 17 years old) who identified with an Asian ethnic group (Chinese = 537; Indian = 365). The findings of the study showed that 13% reported depressive symptoms (12% Chinese; 12% Indian); 15% had suicidal thoughts (15% Chinese; 17% Indian); 8% had planned to kill themselves (9% Chinese; 10 Indian); 4% had attempted suicide (4% Chinese; 6% Indian) and 2% reported inflicting self-harm requiring treatment (3% Chinese; 2% Indian) (Parackal, et al., 2011).

Ministry of Health data on suicide deaths for Asian populations between 1996 and 2010 show that the total number of suicide deaths has increased from 80 between 1996 and 2000, to 84 in 2001-2005, with a further rise to 98 in 2006-2010; annual Asian suicide rates fluctuated between 3.3 and 11.4 per 100,000 people over this period (Au & Ho, 2014):

- The suicide rate for Asian people for the period 2009–2013 is 5.3 per 100,000 (Ministry of Health, 2016).
- In the New Zealand total population, suicide rates for males are about three times higher than those for females. For Asian people, the gender ratio is 1.2:1 in the five years from 2006-2010.
- For Asian groups, suicide rates for 15-24 years of age are 7.2 per 100,000 for males and 3.7 per 100,000 for females (Ministry of Health, 2016).
- Between 1996 and 2010, suicides in the three Auckland DHBs accounted for increasing proportions of the total suicide deaths among Asians, from 52.5 percent in 1996-2000 and 61.9 percent in 2001-2005, to 67.3 percent in the five years between 2006 and 2010.

**Risk factors**
(Au & Ho, 2014).
- Individual risk factors for suicide among Asian populations are similar to those found in Western studies, namely the presence of depression or related mental disorders.
- Additionally, a history of substance or alcohol abuse or misuse, and previous suicide attempt(s) are noted risk factors.
- Acute life events which create stress can be risk factors for suicide. Job or financial losses, family conflict, relational losses, and academic pressure are some common risk factors for suicide in Asian communities.
- Culture and the impact of acculturation play a key role in influencing suicidal behaviour. Migration is accompanied by major cultural transitions such as the disruption of traditional family structures and the changing roles of its members. A wide range of risk factors associated with migration has been recognised: acculturation and settlement stress, family conflict, social isolation, discrimination, loss of social support networks; as well as barriers to accessing mental health services. These factors can contribute to
suicidal behaviours directly, but they can also contribute indirectly by influencing individual susceptibility to mental disorders.

Perfectionism
Among suicide risk factors, perfectionism has been emerging as an important consideration (Choi et al., 2009; Dean, Range, & Goggin, 1996). Perfectionism is described as “harboring excessive personal standards” (Castro & Rice, 2003, p. 64) and is conceptualised in three dimensions: self-oriented perfectionism, other-oriented perfectionism, and socially-prescribed perfectionism (Hewitt & Flett, 1991). Self-oriented perfectionism refers to a tendency to set high, unrealistic personal standards while having difficulty accepting one’s flaws; other-oriented perfectionism refers to having an unrealistic standard for one’s significant others; and socially-prescribed perfectionism refers to a belief that others hold high, unrealistic expectations of the individual (Hewitt & Flett, 1991). Some studies have found that in youth, socially prescribed perfectionism predicts suicide ideation above and beyond hopelessness and depression (Choi et al., 2009; Dean et al., 1996).

Culturally informed risk assessment and prevention
Addressing cultural factors is very important in developing strategies to prevent suicide in Asian clients (Ho, Au & Amerasinghe, 2015)

Behavioural definitions
- Expresses a generalised fatalism about life and an absence of hope for the future
- Displays symptoms of depressive disorder (e.g., lack of energy, anhedonia, or social withdrawal).
- Has a history and current practice of substance abuse.
- Extremely invested in pleasing others to gain affirmation.
- Demonstrates a life-long pattern of an inability to access or process emotions.
- Expresses despair over the inability to meet the expectations of the extended family which results in losing family support, affirmation, and a sense of belonging.
- Life-long pattern of impulsive behaviours and poor problem-solving ability.
- Verbalises extreme feelings of self-devaluation, isolation, aloneness, and self-hate.
- Experiences a chronic pattern of suicide ideation with or without a plan.

Long-term goals
- Embrace life with hope for the future.
- Enhance the development of coping strategies and problem-solving skills.
- Resolve feelings of worthlessness, self-hate, and isolation that contribute to depressive reactions and the impulse to suicide.
- Respect vulnerability to depression and remain on physician-monitored prescription medication.
- Resolve feelings of perfectionism and develop intrinsic self-worth.
- Enhance access to emotions that allow involvement in intimate relationships.
Cultural considerations for therapists
(Choi, Rodgers & Werth, 2009).

- To facilitate self-disclosure with Asian youth, therapists should openly discuss the importance in the assessment process, provide appropriate assurances related to confidentiality, and explore and identify specific barriers to disclosure as perceived by the client. This process should result in strengthening the therapeutic alliance and should improve the validity of the assessment information.

- In the case of international student ensure that the young person’s guardian is identified and engaged.

- Consider that an Asian clients’ reluctance to disclose does not necessarily convey an unwillingness to engage in the assessment process. It is prudent to actively explore potential suicide-related thoughts, feelings, and behaviours in a culturally sensitive way (e.g., one might say “Other patients with these symptoms sometimes lose hope, do you have thoughts of giving up?” (Chen et al., 2002, p.241).

- Asian clients often underreport their psychological symptoms and deny previous suicide attempts for fear of shame. Therapists may find it useful to ask about “any unusual injuries or accidents that have occurred to family members” (Chen, Chen & Chung, 2002, p. 242), when exploring possible suicidal behaviour with Asian youth or their relatives.

- In addition to the potential psychological consequences of acculturation (see the intergenerational conflict section), understanding the client’s level of acculturation and role as a cultural broker may facilitate effective work with suicidal clients. For example, when therapists find a suicidal client to be a cultural broker in the family, they may need to pay greater attention to adequately preparing the family to access resources and to use appropriate referrals in the community.

- Exploring clients’ experiences of acculturation, may provide important risk assessment information. For example, when an Asian client appears “too” dependent and “overly” concerned with his or her parents’ reactions, it could be a reflection of cultural values rather than a sign of immaturity. Therefore, discussing independence and autonomy might not be appropriate. In fact, it may be that focusing on interdependence rather than independence can be helpful in moving the client away from the conclusion that death is the only way out of an irreconcilable culture clash.

- Somatic presentations of emotional distress reflect the Asian concept that mind and body are part of one system. Individuals with traditional Asian beliefs would likely express emotional distress as health concerns. Asian youth may feel misunderstood if therapists conceptualise presenting symptoms as defence reactions that call for deeper
### Cultural considerations for therapists
(Choi, Rodgers & Werth, 2009)

In dealing specifically with suicidal clients, Chen, Chen and Chung (2002) suggest that clinicians frame depression as a medical illness associated with a neurochemical imbalance in the brain, to couch inquiries with cultural sensitivity and to treat psychological illness from the unified perspective of mind and body.

- Therapists should assess the impact of intergenerational conflict as a potential indicator of suicidal risk. However, it is also important to recognise that such conflicts can be a normative consequence of acculturation. Intergenerational conflict is a salient suicide risk factor for Asian youth. Therapists can help Asian young people to normalise their intergenerational conflicts by helping them to recognise conflict as a common component of cultural adaptation (Chung, 2001). This can help to minimise the shame associated with seeking counselling and can increase the therapist’s credibility with Asian clients.

- Therapists should help set realistic goals and reduce self-doubts. Asian youth are more likely to be anxious about making mistakes, experience more parental criticism, and have more self-doubt than European students.

- To assist students in better managing their stress, therapists could implement specific treatment plans to teach stress-management skills and to encourage developing realistic goals. In addition, when working with clients’ families, therapists may want to assist students in setting priorities by helping them to see that academic work can wait, while psychological health cannot.

- When working with Asian youth, therapists need to seek consultation from others with expertise in the specific cultural variables associated with suicide (Kleespies et al., 1999).

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### Cultural considerations for general practitioners
when working with a CALD young person assessed with high suicide risk

- Allow as much time as possible, speak slowly and clearly, use short sentences, and repeat yourself regularly.

- Where the young person is accompanied by a parent, try to see the young person on their own and explain to the parents your reasons for doing this. Be aware that this may be considered culturally inappropriate and disrespectful of the parental role. Seek parental permission first before you seek the young person’s consent.
### Cultural considerations for general practitioners when working with a CALD young person assessed with high suicide risk

- When helping a young person at risk of suicide who is non-English speaking or who speaks English as a second language, communicate clearly. Encourage the person to use their preferred language, especially in stressful situations. *People often lose their skills in a second language in stressful situations.*

- Use a professional interpreter to assist communication if needed. *If a face to face interpreter is not available use a telephone interpreter.*

- Try to establish a relationship and build a sense of trust. *Trust, confidentiality and respect for individual beliefs and attitudes are paramount.*

- Clearly explain your role, services, how the health system works and confidentiality.

- The person may express themselves in ways you are not used to. Be aware that *people interpret suicidal experiences though a range of cultural, spiritual and religious understandings. Be aware of different values and idioms of distress.*

- Provide close monitoring and appropriate support
Psychosocial Interventions

Managing Depression

Some Asian, Middle Eastern and African parents may be less likely to endorse beliefs that are consistent with a biopsychosocial model of mental illness than are European parents (Stewart et al., 2012; Yeh et al., 2004). Asian and other CALD parents are more likely to endorse sociological causes (eg bullying, racism and discrimination, peer influence) (Vontress, 2007). These attributions contraindicate the kind of help provided in traditional mental health settings. The literature points to higher stigma against mental illness in CALD groups, and the relationship between parental knowledge and acceptability of treatment. Two sets of variables appear to play an important role in help-seeking and the ability to benefit from formal systems of mental health care for CALD children and young people (Stewart et al., 2012): beliefs about the causes of and solutions to mental illness; and knowledge about treatment options and their efficacy. Of particular concern is that practitioners may underestimate their CALD client’s and their parents’ need for psycho-education and of the encouragement needed to communicate information about the side-effects of medication. These factors may together contribute to lower rates for effective treatment of CALD adolescents. The following points will improve communication and engagement with CALD clients and their families:

• Many instruments to screen, assess severity, or track depressive symptoms have not been normed for ethnic minority youth. Their use should be supplemented with qualitative information (see the CALD Assessment Tool for Children and Young People and the Assessing Intergenerational conflicts tool in the Assessing Migrant and Refugee Children and Adolescents section).

• Be aware of diagnostic bias, such as over diagnosis of disruptive behaviour disorders in ethnic minority boys. Be careful in assessing previously diagnosed youth or those who may present with symptoms that obscure an underlying depressed mood.

• Clinicians can play an important role in observation and delineation of common presentations that fall outside the formal templates for diagnosis (see Somatic presentations in the Cultural Presentations of Distress section and the Cultural Formulation Interview tool) (see the Assessing Migrant and Refugee Children and Adolescents).

• Health literacy can be lower, particularly in less acculturated clients and parents. Clients and parents who do not ask about or voluntarily communicate information about side-effects may be at risk of low adherence.
Family Therapy

Effective therapy with Asian families requires that therapists be flexible in their therapeutic approaches, and become more knowledgeable about Asian cultural beliefs, values, and norms. There are at least three issues that can intrude and negatively affect therapy with CALD families and the outcomes. These are: (a) dissonance between the basic cultural positions of the therapist and the family, (b) lack of therapist credibility with the family because of gender, and (c) lack of therapist credibility with the family because of cultural differences (Baptiste, 2005).

a) Dissonance between the basic cultural positions of the therapist and the family

Asian families’ philosophy of life, irrespective of country of origin, emphasises children’s hierarchical deference and obligation to the family, including extended family. Conversely, western philosophy emphasises individualism and personal growth through separation and individuation from the family of orientation.

Given the core differences between the egalitarian orientation of western cultures and the collectivistic orientation of Asian families, there are discrepancies between European therapists and Asian families with regard to their worldview and priorities for parenting. For example, in working with families experiencing intergenerational difficulties many therapists discover that their value orientation towards differentiation and independence of adolescents and young adults often conflicts with parents’ traditional values of familism that demands unqualified deference to parents and extended family, and is usually equated with family loyalty. Consequently, European therapists’ who attempt to either outright replace or move too quickly to have Asian families modify their values will be ineffective. If these differences are not addressed in therapy, there is an increased likelihood that both the therapist and family could experience frustration, which could contribute to the family’s premature termination from therapy.

b) Lack of therapist credibility with the family because of gender

Traditionally, within Asian cultures, families are patriarchal, and women’s roles, other than motherhood, are not accorded the same importance as men and their roles. Consequently, although some Asian families emigrated from countries (eg, South Africa) in which women function in professional roles such as physicians and lawyers, many family members, especially males, regardless of age and education, tend to be uncomfortable with women as professional psychotherapists. Consequently, despite a female therapist’s skills and training, the family may in all likelihood, reject her as a therapist, because of her gender. On occasion, even adolescents, males as well as females, may also reject the female therapist’s help or more importantly sabotage her therapeutic efforts. Similarly, female therapists, feminist oriented therapists in particular, who may attempt to bond or establish sisterly rapport with female family members may be discouraged by the females’ lukewarm reception, and
rejected by the males who often view such joining as a threat to the family’s collectivist values.

c) **Lack of therapist credibility with the family because of cultural differences**
Therapy with any client tends be most effective when therapists share similar group membership to those of their client because such similarity enhances the therapists’ credibility. In this context, credibility refers to a family’s perception of the therapist as an effective and trustworthy helper. Working with any family’s system, especially a family from a different membership group than the therapists own, therapist’s are confronted with two kinds of credibility - ascribed and achieved. Ascribed credibility refers to the therapist’s knowledge of the cultural background, including values, norms, and lifestyles, for example, of the family, and is assigned by the family to the therapist. Achieved credibility refers to the therapist’s clinical skills. Because western therapists and Asian families do not share a similar membership cultural group, Asian families may perceive such therapists to be lacking the necessary ascribed credibility (as determined by the particular family), and may be hesitant or even resistant to engage in therapy with such therapists. Consequently, it is important that western therapists maximise their ascribed credibility to enhance the family’s perception of them as trustworthy and effective helpers.

Western therapists’ lack of credibility with Asian parents because of cultural differences, can often contribute to the therapist feeling therapeutically impotent in his or her efforts to effect change in the family’s system. For example, therapists who use their achieved credibility (ie, clinical skills) to encourage an Asian wife or child to confront the husband/father in therapy may find both the wife and the child resistant to doing so, because of the discordance of the suggestion with the family’s traditional cultural norms for husband-wife and parent-child relationships. By so doing the therapist’s achieved credibility is diminished and he/she becomes impotent as a change agent. Because of the incompatibility of the therapist’s suggestion with the family’s cultural values, not only does the wife resist acting upon it, she may ally with the husband/father against the therapist, making intervention futile. Such resistance can negatively affect the therapeutic process, contribute to premature termination of the family from therapy or worse, the family politely remains in therapy but does not change its behaviours.
The following case study illustrates family therapy with Indian migrant parents, acculturation issues with adolescents, and recommendations for psychosocial engagement. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

**Case Study 10: Family therapy (Indian)**
(Adapted from Baptiste, 2005).

Dr Patel and his wife are doctors, an ear, nose, and throat specialist and a GP respectively. Their son Divesh (age 16) was referred for family therapy by a colleague, 10 years after migrating to New Zealand. A younger son (age 12) and a daughter (age 5), complete the family. At interview, the parents, in particular the mother, presented a long and detailed list of Divesh’s transgressions which included: partying on the weekends and staying out later than his parents approved, staying over at a Kiwi friend’s home without parental permission, drinking beer and eating hamburgers (the family was vegetarian), dressing in ways unacceptable to his parents, and most damaging of all, he wanted to study to become a psychologist rather than the doctor his parents expected him to be. According to his mother, Divesh had been a model child until a year ago. She said, “he listened to his parents and did not give us trouble”. All that changed when he joined the school soccer team and began to associate more closely with his Kiwi peers in the team. His mother attributed Divesh’s behavioural and attitudinal changes to the negative influences of three specific teammates whom she accused of corrupting Divesh such that he had become “more like a Kiwi child than the Indian child they believed they were raising”. Divesh’s mother’s perception of Kiwi children and parents, in particular adolescents and their parents, was very unflattering; she believed herself to be a much better parent than her Kiwi counterparts. As a result of the parental objections, Divesh was withdrawn from the soccer team and many of the freedoms he previously enjoyed were severely curtailed. Divesh’s mother’s displeasure with Kiwi culture intensified when the soccer coach visited the parents to persuade them to allow Divesh to rejoin the team. She concluded that the coach was more interested in Divesh “becoming a soccer player than being a good boy who listens to his parents.” He did not rejoin the team.

Divesh was very critical of his mother. He accused her of, “liking to be in New Zealand for the money but not liking Kiwis”, and “thinking that you are better than everybody and wanting me to be Indian in New Zealand”. From his perspective, the behaviours his mother found objectionable were necessary to “fit in” with his peers. He pointed out that he still maintained very high marks in high school and was a member of the chess and mathematics clubs. Furthermore he did not complain much when his parents, primarily his mother,
refused to buy him a car, “even though you can afford it.” Divesh’s father did not say much, but what he said was less intense than his wife. He acknowledged the difficulty of raising children in New Zealand given “the night and day” differences of expectations for children’s behaviours in NZ and India. He also acknowledged that, “Divesh is a good boy” and that “everything was different for all of us.” He solicited the therapist’s assistance to find the family “a workable middle ground.” Accordingly, therapy focused on helping Divesh and his parents to explore compromises and alternatives to being polarised, within a workable middle ground.

| Question 1: How will you engage with the family? |
| Question 2: How will you approach changes within the family system? |
| Question 3: What stance will you take in regard to the intergenerational conflict? |
| Question 4: What other underlying issues may be involved and how will you address these? |

*Discussion notes are available under the “Case studies-discussion notes” section.*

**Cognitive Behavioural Therapy**

The available studies indicate that refugee and migrant youth will likely benefit from CBT in the same ways as non-migrant youth (Benish et al., 2011; Cardemil, 2010; La Roche & Christopher, 2009; Kazdin, 2008). Demographic characteristics such as age, gender, ethnicity, and symptom severity do not impact CBT’s effectiveness (Huey & Polo, 2008; Huey et al., 2014; Kendall et al., 2008; Walkup et al., 2008). The past 20 years has produced studies that support the use of CBT to treat youth who present to treatment for anxiety (Kendall et al., 2008; Franklin et al., 2011), and depression (March & Vitiello, 2009), posttraumatic stress disorder (Cohen et al., 2009), disruptive behaviour (Lochman et al., 2011), and challenges associated with autism spectrum disorder (White et al., 2013), substance use disorders (Waldron & turner, 2008), and eating disorders (Keel & Haedt, 2008). CBT is an effective treatment model appropriate for youth for a wide range of presenting problems and cultural identities (Friedberg et al., 2016).

A number of studies have examined whether culturally adapted forms of cognitive behavioural therapy (CBT) are more effective than are non adapted forms of CBT, whether culturally adapted treatment demonstrates positive outcomes, or whether certain components of CBT are more helpful than others (Jackson et al. 2006, Shen et al. 2006). These studies are important because CBT is effective for many different problems (eg, anxiety and depression) and for different ethnic populations. For example, Hinton et al. (2005) used CBT to treat Cambodian refugees by using culturally appropriate visualisation tasks. Furthermore, because CBT is often delivered with a fixed format or manualised script, it can readily incorporate cultural adaptations and be tested. Findings from the CBT studies...
provide consistent indications that cultural competency interventions are effective, and two of the studies (Kohn et al. 2002, Miranda et al. 2003) found that cultural competency adaptations to CBT were superior to nonadapted CBT (Stanley et al, 2009).

This section defines and illustrates content and process factors that comprise competent CBT for refugee and migrant youth. Case scenarios from the work of Friedberg et al. (2016) demonstrate the ways that CBT can be modified to address the cultural factors salient to practice with migrant and refugee youth.

**Target Monitoring**

Target monitoring is the data collection phase of CBT treatment and serves to both increase awareness and establish a baseline of symptoms. Clients and/or parents are asked to track thoughts, feelings, behaviours, and physiological sensations—essentially, clients gather information relevant to their presenting problem (Friedberg & Gorman, 2007). Thought records are one example of a method for monitoring automatic thoughts, situations that elicit particular beliefs, and patterns of cognitive distortions (Friedberg & Gorman, 2007). Target-monitoring techniques can and should be adapted to the patient’s age, cultural background, interests, etc. (Friedberg et al., 2016). For example, young children respond well to filling in faces with expressions or colouring in a thermometer to reflect the intensity of their emotions; adolescents may simply report intensity on a scale from 0 to 10.

Cultural adaptations can easily be integrated into the target monitoring phase as well. For example, a young Chinese client may experience her anxiety primarily as somatic symptoms such as stomach ache, numbness, tingling, and a racing heart. As a result, monitoring somatic symptoms and physiological arousal using culture-specific language (eg blockages of Xi) rather than asking her to rate her anxiety will make this activity more relevant.

Clinicians can also utilise self-report measures such as the Children’s Depression Inventory (CDI-2 (Kovacs, 1992) and Screen for Child Anxiety Related Emotional Disorders (SCARED) (Birmaher et al., 1997). The CDI-2 is available in English and Spanish, and the SCARED is available in Arabic, Chinese, English, French, German, Italian, Portuguese, and Spanish. These measures allow young clients and families to monitor symptoms over time using an objective assessment.

Target monitoring also facilitates functional analysis of problem behaviours by identifying antecedents and consequences. Furthermore, monitoring emotional intensity in response to feared situations enables clients and clinicians to collaboratively develop a hierarchy of feared stimuli for graduated exposure. Target monitoring provides essential data that guides later phases of treatment (Friedberg et al., 2016).
The following case study illustrates CBT for PTSD with a child from a refugee background. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

**Case Study 11: Cognitive behavioural therapy (Sudanese)**
(Adapted from Friedberg, et al., 2016).

Nico (13), his 19-year-old sister and 24-year-old aunt are refugees from Sudan. Nico developed school refusal a year after arrival in New Zealand. The school was a much larger and more chaotic than the academic environment he experienced in Sudan; Nico also hated the loud bells that rang often throughout the day. He experienced substantial physiological hyperarousal upon arriving on school grounds and hated the way his skin “crawled”. Nico spoke often about his desire to be in a “peaceful” place and reported that the school was so aversive because it was the “opposite” of peace. When training Nico in breathing exercises, the clinician likened the activity to “breathing in peace, and breathing out chaos.” Pairing Nico’s desire for peace with the behavioural intervention gave him a concrete understanding of how the exercise helped him to achieve his goals.

**Question:** Describe the CBT treatment approach and why it was successful.

Discussion notes are available under the “Case studies-discussion notes” section.

The following case study illustrates CBT for OCD with a Japanese adolescent girl. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.

**Case study 12: Cognitive behavioural therapy (Japanese)**
(Adapted from Friedberg, et al., 2016).

Asuka, a 14-year-old Japanese girl, migrated to New Zealand with her parents, brother, and grandparents when she was 10. Asuka was diagnosed with OCD and displayed contamination fears related to “sharing air” with people; she could not talk to others unless she stood several feet away to ensure she breathed “fresh” air. This dramatically interfered with her ability to develop a social support system despite the fact she found a group of girls who shared her passions for anime and manga—animated adventures in video and graphic novel formats. When she reached the cognitive restructuring module, her therapist
suggested that she make her own manga to chronicle her “battles” against the OCD. Asuka delighted in the exercise and created extraordinary pages illustrating her cognitive contests against the OCD villain living in her mind. Not only did this exercise make cognitive interventions literally come alive for Asuka, it also established a way for her to open communication with her friends.

**Question:** Describe the CBT treatment approach and why it was successful.

*Discussion notes are available under the “Case studies-discussion notes” section.*

The following case study illustrates CBT for behavioural issues resulting from bullying in a girl from a refugee background. The case study provides a question for viewers to consider and reflect on. *Discussion and suggested approaches for this case can be found under the Case Studies and Discussion Notes section.*

**Case Study 13: Cognitive behavioural therapy (Iraqi)**

(Adapted from Friedberg, et al., 2016).

Aliyah, age 11 is Iraqi; she and her parents left Iraq when she was 3 and moved in with an aunt, uncle, and four cousins in New Zealand. Her parents brought her to therapy for treatment of anger outbursts that occurred solely in the context of school. Upon intake, Aliyah had been suspended twice for fighting. Her parents were so perplexed by her behaviour; they were considering sending her back to live with family in Iraq. Therapy revealed that Aliyah was lashing out at peers physically in response to racially motivated bullying at school. Aliyah lacked the complex language skills to be able to “fight back” with her words.

Aliyah created a hierarchy specific to the behaviours of her peers that “made her explode.” The lower-rated behaviours included people staring at her, pointing, and whispering and then climbed to name-calling and physical contact (eg, pushing her).

After learning skills to use when she “got hot”, Aliyah and her therapist went out into the waiting room wearing different props to attract people’s stares. Aliyah noted that she did not feel as angry when adults looked at her as she did when other youth did. Therefore, to make the exercise more relevant, Aliyah and her therapist went to sit in a paediatrician’s waiting room.

For the final step, Aliyah and the therapist went into a crowded café close to the clinic to
practice how to remain calm when others bumped into her. When they first began this step, Aliyah’s father came to the café with them. Aliyah realised that she felt safe with her father near, stating “he will always take care of me.” Thus, they pursued further practice with no parent nearby. Because the therapist attended closely to the level of emotional activation evoked by the interventions, Aliyah was able to generalise her learning to the school environment and finished the academic year without another fight.

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<tr>
<th>Question 1:</th>
<th>Describe the CBT treatment approach and why it was successful.</th>
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<td>Question 2:</td>
<td>What suggestions can clinicians make regarding stopping the racial bullying in this case?</td>
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Discussion notes are available under the “Case studies-discussion notes” section.

Cultural adaptations to CBT produce lower attrition rates and greater patient involvement in treatment among ethnic minority patients. Thus, if the particular cultural alteration (eg, including extended family in sessions or predominantly targeting physiological symptoms rather than including cognitive) keeps more children in treatment and offers equivalent effectiveness, the change represents a good standard of care (Cardemil, 2010). However, cultural adaptation must preserve the core treatment ingredients of CBT while allowing for flexible integration of diverse perspectives and values (Friedberg, et al., 2016).

**Psycho-education**

Psychoeducation involves orienting youth and their parents to the treatment process. This includes providing information about the child’s presenting problem and discussing what to expect from the treatment approach (Friedberg & Gorman, 2007). Introducing families to the therapy process is particularly important with migrant and refugee youth, whose families may not be familiar with psychotherapy. Explaining what to expect, addressing misconceptions, and providing information about the young client’s symptoms facilitates motivation and investment in treatment (Friedberg et al., 2009). Skillful psychoeducation contributes to engagement in treatment. For example, using culturally and individually relevant metaphors to explain treatment fosters understanding and builds the therapeutic relationship. Culturally relevant analogies can also be used in describing the structure of cognitive-behavioral treatment. With youth, it is particularly important that clinicians are creative in the implementation of psycho education. For example, multimedia including picture books, movies, songs, pamphlets, websites, and TV shows can be employed to communicate critical information (Friedberg, & Brelsford, 2011).

Practitioners should strive to provide information in a variety of different mediums to facilitate understanding and meet the needs of each family. For example, parents can be given printed material from websites and clinicians can read a picture book with young children (eg Children’s guides to overcoming anxiety). Psychoeducational material should be
presented in the preferred language of parent and child (see section on Resources for Consumers).

**Strengths-based approach for refugee children**

The Child and Family Refugee Service at the Tavistock Centre in London have run a series of ‘Tree of Life’ groups for both parents and children in schools (Hughes, 2014). The groups were developed in response to a concern about the majority of psychological treatments, which focus predominantly on vulnerability factors in refugee populations, and the effect that this can have on those they are attempting to help. In addition, these are modelled on western assumptions, which do not adequately take account of culture. The Tree of Life groups have provided an alternative to traditional mental health services, which many refugee families find difficult to access because of perceived stigma and lack of knowledge about what is on offer. The groups employed a strengths-based narrative methodology, using the tree as a creative metaphor, which enabled parents and children to develop empowering stories about their lives, which are based in their cultural and social histories. From this secure base, participants are able to develop shared, culturally congruent solutions to their problems. The groups have been found to benefit parents and children alike, as well as the school communities in which they have taken place (Hughes, 2014).

**Challenges facing refugees in accessing mental health services**

Bracken, Giller, and Summerfield (1995) argue that current concepts embedded in psychological responses to war and atrocity is limited for a number of reasons. Firstly, the notion of individuality, which is the underlying philosophy, has been derived from western culture but is not universal. Secondly, is the assumption that all cultural groups will respond to traumatic experiences in the same way, and present symptoms and signs of distress that can be understood across different settings. In fact, the validity of commonly used diagnoses, such as Post-traumatic Stress Disorder (PTSD), has not been established across different cultural groups (Kleinman, 1987). Thirdly is the idea that treatment approaches developed in the West are accepted as the best approaches to adopt even with non western populations, and that ‘healing in a world-wide context is a multi-faceted phenomenon’ (Bracken et al., 1995). They caution that if western models of therapy are applied universally, then this expertise may undermine local community structures which can in themselves be crucial to protecting people from the effects of trauma. In addition, these dominant discourses of Western expert knowledge can silence the marginalised cultural discourses about how mental or emotional distress is understood, thereby undermining the very identity of the people this is attempting to assist (Hughes, 2014).
The ‘Tree of Life’ approach
Ncube (2006) describes how the Tree of Life uses the tree as a creative metaphor on which people are invited to map out their lives. People begin by tracing their cultural and social histories in the roots, which may include writing or drawing such things as where they have come from, their family origins, those who have taught them most in life, their religious roots, or a treasured song. The ground contains features of their current lives, including where they live and what they are doing now. Strengths and abilities are mapped onto the main trunk of the tree, which may be identified by what others have observed of them, and stories are told about how these skills have been developed. Finally, hopes and dreams for the future are put in the branches of the tree, with the names of important people from the present and past on different leaves, and gifts that the person has been given in the fruits of the tree. Through a process of narrative questioning, people are invited to build rich descriptions of their lives, identifying their resources and skills, the social history of how these developed, and how these can lead them towards their desired future. Having built up these rich descriptions, people then share their trees with each other, giving words of encouragement, and talking together about how to face ongoing challenges and respond in ways that are congruent with their cultural values. Finally, people are invited to share their trees with important people in their lives, either by writing letters to these people, or by inviting them to celebrations of their work at which they are given certificates acknowledging their strengths and achievements (Hughes, 2014). Ncube (2006) and Ncube-Milo and Denborough (2008) provide detailed descriptions of how this approach works in practice. The Tree of Life approach is a particularly appropriate psychosocial intervention for refugee communities for a number of reasons (Hughes, 2014):

• As it is a visual method where information can be conveyed through imagery, it can be helpful where English is not a first language and verbal communication is limited.
• The process involves each person producing a personal document that can be shared with others, which helps to take the work beyond the immediate group. White and Epston (1990) write about the importance of witnessing (others hearing about our preferred versions of our lives) as a way of consolidating and supporting change.
• The approach fits with a storytelling tradition, which is an important component of the heritage of many refugee communities.
• The Tree of Life grounds people in their communities, past and present, and invites them to recognise and draw on potential support within their social networks. For refugees, in particular, who have often experienced the traumatic loss of these important relationships, this can be a very powerful process.
• Even when people are displaced and so much is lost from their lives, the Tree of Life is a way of helping connect with past hopes and resources that can continue to sustain them in their daily life.
• The methodology creates a context from which traumatic responses can be understood so that people do not experience these as a sign of weakness and a point of shame. As
Collaborative mental health care for refugee children

Primary care services, including clinics, schools and community organisations, because of their closeness to the family living environment, are often in a good position to detect problems in traumatised refugee children and to provide help. In a collaborative care model, the child psychiatrist consultant can assist the primary care provider and family in holding the trauma narrative and organising a safe network around the child and family. The consultant can support the establishment of a therapeutic alliance, provide a cultural understanding of presenting problems and negotiate with the provider and the family, a treatment plan. In many settings, trauma focused psychotherapy may not be widely available, but committed community workers and primary care professionals may provide excellent psychosocial support and a forum for empathic listening that may provide relief to the family and the child (Rousseau, Measham & Nadeau, 2012).

Advocates of collaborative primary mental health care for children and adolescents underline its compatibility with systemic approaches which are likely to improve shared decision making and responsibility among providers (Chenven, 2010). Primary care health and social services often express a need for assistance in understanding cultural differences in the mental health consequences of organised violence and in understanding the strategies used by families and communities to cope with trauma. In addition to addressing cultural differences, situations involving children affected by extreme human-perpetrated harm often provoke strong emotional reactions in caregivers. Collaborative mental health care models can help to address these information- and practice-based needs.

This section describes a cultural consultation model in youth mental health collaborative care in Canada including a case scenario of refugee children who have experienced different forms of direct or transgenerational trauma, in order to describe the process of cultural consultation in a primary care setting. The case scenario is used to illustrate the different steps of the process of cultural consultation in a primary care setting in order to highlight three issues that are at the forefront of cultural consultation requests for refugee families: alliance building, assessment and treatment. The challenges of cultural consultation in collaborative care settings addressing refugee children’s mental health are also discussed.
The collaborative care setting

The collaborative mental health care project in Montreal, Canada has been implemented in community-based health and social services clinics servicing multi-ethnic neighbourhoods. Of the children and adolescents living within these clinics’ territories, 80% are first (35%) or second (45%) generation migrants or refugees. Some of these children experience difficulties related to resettlement or to a previous experience of organised violence and few formally seek mental health support. The goal of the project is to provide mental health services to children through community-based clinics. Partners include first line health professionals involved in the psychosocial care of children and adolescents, such as general practitioners, community nurses, social workers and child care workers; as well as schools and community organisations (Rousseau, Measham & Nadeau, 2012).

Each clinic has a Youth Mental Health Team which provides mental health care directly to children and families, and which also supports the work of other teams in the community clinic delivering general health and psychosocial care to the families. Bridges with community organisations and schools contribute to the establishment of support networks for the families. This systemic approach facilitates the appraisal of the child and family’s difficulties within a broader social and cultural perspective and the formulation and implementation of intersectoral (such as school–clinic–community organisation) intervention plans (Rousseau, Measham & Nadeau, 2012).

The following case study illustrates a collaborative intersectoral approach to mental health care for children from refugee backgrounds. The case study provides a question for viewers to consider and reflect on. Discussion and suggested approaches for this case can be found under the Case Studies section.

Case Study 14: Collaborative mental health care for refugee children (Sri Lankan)
(Adapted from Rousseau, Measham & Nadeau, 2012).

This cultural consultation involved three meetings over a two-year period between the public health nurse (PHN), Mary, who visits schools and day care centres in the area where the CAMHS clinic is located, and a child psychiatric consultant. Mary is the main health professional providing care for Shiva, a young boy who arrived in New Zealand at the age of four with his mother Anna. Shiva was born into a happy, wealthy, well-educated family in Sri Lanka. When Shiva was three, his father was kidnapped for political reasons and subsequently killed. Shiva and his mother were called to the hospital where, instead of finding Shiva’s father alive as they expected, they had to identify his tortured dead body. Anna, who was pregnant, was unable to protect Shiva from the horrific sight. Soon afterwards, Shiva and his mother were abducted and tortured, and Shiva witnessed his
mother’s mistreatment.

Later, relatives smuggled them out of the country and they arrived in New Zealand where they applied for refugee status. On arriving in New Zealand, Anna had to be hospitalised because the torture had provoked a miscarriage. For an entire week, she lay between life and death in intensive care. Shiva sat quietly on a chair by her bedside (very surprisingly, he was not placed in a foster care setting). It is not clear whether Anna was discharged without a referral for further mental health care services or whether she did not attend follow-up appointments.

The family’s next contact with health and social services was established through Shiva’s day care. The day care workers were worried about Anna’s distrustful and avoidant behaviour. They reported that Shiva was extremely withdrawn, hid under tables and appeared to be terrified. They suspected physical abuse and severe neglect. Before reporting him to Child, Youth and Family (CYFs), they decided to consult Mary, the PHN who was their designated primary health care resource person. Mary’s work with Anna involved supporting her in organising a survival network in her neighbourhood. She taught her about food banks and helped her find furniture and appropriate clothing. Mary also helped Anna continue with her application for refugee status. In the process of helping Anna fill out her immigration papers, Mary found out about Shiva’s traumatic background by reading the written narrative that Anna had had to provide for her refugee application – Anna never spoke about this. Mary also became increasingly aware of the ongoing physical pain that Shiva and his mother continued to experience, and was concerned about its relationship with their past traumatic experiences.

Concerned about Anna and Shiva’s experiences, Mary encouraged the mother to consider mental health and medical support for the family, but Anna refused this. At this point, Mary requested a first consultation during which she discussed the situation in the absence of Anna. Mary explained how she had been working to change the daycare workers’ perceptions of Shiva’s mother from a paranoid and potentially dangerous person to a severely hurt woman who, in spite of her fragility and emotional unavailability, was deeply attached to her son. During the consultation, a thorough review of all the services involved revealed that in spite of Anna’s reluctance to see a mental health professional, she had been seeing several doctors for both herself and for Shiva due to medical complaints and had been taking a number of psychotropic drugs, without significant results. Mary was unsure whether or not she should directly address the family’s traumatic story with Anna, stressing the mother’s massive avoidance behaviours and the fragility of their alliance. Moreover, she remained worried about Shiva’s anxious behaviour; although she felt that since her involvement with the family he was showing some signs of improvement. Mary also felt overwhelmed by the story that had been indirectly revealed to her when she helped Anna fill in the immigration papers. She turned to the consultant to obtain confirmation that her
work on the alliance between the mother and the day care, trying to increase the level of empathy of the care providers, was effective. Mary felt a sense of emergency, which had led her to do a lot and to become exhausted. In spite of her intensive involvement, she felt helpless. The anger of the day care workers was framed as a misunderstanding. The consultation provided comfort and helped her shape more realistic expectations. Mary was supported in her continued efforts to help Anna set up a safe and supportive environment for the family, which included helping the mother to continue with her refugee status application. Art therapy was also offered for Shiva, and his mother agreed to this, although she shared that she did not have the energy to take him to the clinic. She did agree to this being provided at the day care by a CAMHS clinic trainee, which offered significant support both for the day care and for Shiva. The consultant also underlined the survival strengths of Shiva and Anna. This helped Mary to break out of the extremely stressful emergency mode of intervention which was burning her out, and helped her understand the feelings of helplessness engendered by her role as the only care provider who Anna would trust.

The second meeting with the consultant took place one year later. This time Anna, Shiva and Mary attended. Mary requested this second consultation to monitor Shiva’s progress and to address family dynamics, as Anna had re-established some connections with relatives in New Zealand. Anna refused the services of an interpreter, even when offered a choice in the interpreter’s gender and ethnic origin, so the consultation took place in English, a second language for all parties involved. Anna shared that Shiva’s fearfulness, including fear of hospitals, had diminished somewhat. In preschool, though still withdrawn, he was clearly a talented and caring little boy. For the first time, Anna was willing to discuss the possibility that her own physical symptoms and Shiva’s numerous somatic complaints could be linked to their traumatic experience. She also began to talk about karma as a means of understanding her past. Finally, with regard to family relations, she alluded to the burden associated with her status as a widow. ‘Is it possible to escape the fate of widows?’ she asked. At the explanatory level, the Western model of trauma causality coexisted with traditional cultural models (karma and the role of the widow) to give meaning to the family’s suffering.

After the second consultation, Mary discussed her feelings of isolation. Anna was refusing to let other people (an interpreter or family members) help or support her. Very invested in the therapeutic relationship, Mary felt protective of Anna and while she did not feel she was angry, she felt overburdened and wanted help to re-establish social links for Anna. Anna finally gave Mary permission to contact their various doctors and to look for one family doctor who would be willing to coordinate all their medical needs. This consultation helped Mary to understand Anna’s ambivalence towards her relatives, opened the door to discussing both the protective (religious) and threatening (the role of widowhood) aspects of tradition and supported the co-ordination of services.
The third consultation took place 10 months later. Mary asked their new coordinating family doctor, Anna’s physiotherapist, Shiva’s art therapist and Anna to attend the meeting. Anna showed up briefly and informed all the professionals that she could not stay. The ensuing discussion revealed splitting processes among the family’s various caregivers. Anna’s anxiety about her son’s and her own medical problems was being transmitted to all with a sense of urgency, along with strong feelings of anger at the inadequacy of treatment and the unfairness of the system. Anna was simultaneously asking for help and portraying the health care providers as aggressors, thus reliving her memories of the hospital scene in Sri Lanka. For her, the health care system had become a theatre of traumatic re-enactment. The consultation helped to resolve the splitting by addressing these issues and changing the perception of the mother among the caregivers. During this third meeting the family’s caregivers argued among themselves about who was not doing enough, contesting the saviour role they each wished to claim, but also share. They projected their feelings of moral obligation onto others and channeled their anger and frustration into the collaborative relationship. The consultant pointed out this splitting, noting that the effect of trauma had influenced the family’s interpersonal relationships. Since Anna’s arrival, the splitting had been shifting from the day care to the extended family, and was finally being replayed among the caregivers themselves. The plan of action proposed a way to coordinate the physical and psychological care of Anna, who now agreed to enter psychotherapy, reframing the conflict as a symptom of the trauma. Mary remained the key player, with the child psychiatrist available to provide support.

Shiva remained very involved in his art therapy sessions. He endlessly built fortresses that were always attacked by monsters and armed men. He also portrayed hospitals as scary places. Gradually, he introduced scenarios that ended in less catastrophic ways, as protection became possible to envision. In the last session, he spoke directly about his father for the first time. The therapist thought that the end of the sessions reminded him of his earlier loss, but also felt that he was offering her a gift, entrusting her with his most cherished memory before leaving.

| Question 1: Describe the issues involved in the therapeutic alliance between the consultant (Child Psychiatrist) and the consultee (PHN); between the PHN and other primary carers; and between the PHN and the client. |
| Question 2: Explain the impact of vicarious trauma on the interactions between health professionals involved in this case and on their relationship with the client. |

*Discussion notes are available under the “Case studies-discussion notes” section.*
For further information on psychosocial interventions and best practice for working with Asian, migrant and refugee background children and adolescents go to:


Summary

Many CALD families attempt to deal with their psychological problems without seeking professional services and tend to rely on the family in dealing with their problems. Many come to mental health professionals as the last resort. There is increasing evidence to suggest that treating clients and families in a more culturally sensitive manner can reduce treatment failure. Without culturally appropriate and linguistically compatible services there is the potential for misdiagnosis. Cultural presentations of distress and culture-bound syndromes may not fit within western normed diagnostic categories. The DSM-V offers an adaptive interview technique (the Cultural Formulation of Diagnosis) to compensate for the cultural insensitivity of diagnostic instruments. Due to Asian, Middle Eastern and African traditions of viewing the body and mind as unitary rather than dualistic, clients tend to focus more on physical than emotional symptoms, leading to an overrepresentation of somatic complaints.

CALD clients and families respond well to highly structured psychosocial interventions such as those used in behavioural, cognitive, and interpersonal models. When applying pharmacotherapy, clinicians should pay attention to Asian and African unique responses to psychotropics, especially in regard to dosage requirements and side effects.

Although it is necessary to emphasise the heterogeneity of Asian and other ethnic minority groups, it is equally important to acknowledge a certain level of cultural similarity among them. For example, Asian families place a high value on collectivist family values rather than the individual. The individual is seen as the product of all the generations of his or her family. Because of this continuum, an individual's personal action reflects not only on himself/herself but also on his/her extended family and ancestors. An individual is expected to function in his or her clearly defined roles and positions in the family hierarchy, based on age, gender, and social class. Obligations and shame are the mechanisms that traditionally help to reinforce societal expectations and proper behaviour. There is an emphasis on harmonious interpersonal relationships, interdependence, and mutual obligations or loyalty to family.

Most parents demand respect and obedience from their children. In many extended families, children are not solely raised by their parents but are cared for by a wide range of adults (grandparents, uncles, aunts, cousins). Traditional Asian cultures avoid open conflict. Family conflict is frequently managed by role segregation, indirect communication, and polite inattention. The strong hierarchy within the family defines who may voice an opinion and who must suppress it.

Increasingly, Asian migrant parents and their children are being referred for family therapy because of parent-child conflicts. Many of the problems parents and children bring to
therapy result from intergenerational relationship strains, and the adolescent, or young adult separation-individuation occurring in an unfamiliar context under different cultural rules. To be clinically effective therapists need to be knowledgeable about Asian/MEA family values, norms, and traditions, be flexible in their psychosocial approaches, and create an atmosphere in which both parents and children feel valued and respected.

**Case Studies and Discussion Notes**

This section provides all the case studies presented in this resource with additional discussion notes. A reference where each case is located in the resource is noted after the questions of each case. The only case not presented in this section is case study 7.

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**Case Study 2: Screening for autism (Vietnamese)**
(Adapted from Massachusetts Act Early (MA Act Early), (2017)).

Mrs Buivan arrives for an appointment with her three year-old Tran. Tran’s mother speaks only Vietnamese so you call the telephone interpretation line because you were not aware that an interpreter would be required. Through the interpreter, Mrs Buivan reports that she is worried because Tran only uses three to four words and has “bad” behaviour, such as temper tantrums and not listening. He also sleeps poorly and is a picky eater.

Mrs Buivan shares that she has been concerned about Tran since before he turned two. He is very different from his two older sisters. She shared her concerns with the Plunket Nurse at Tran’s 24-month well-child visit, but was told that boys often talk later than girls, he was hearing both Vietnamese and English at home (through television and his sisters), and she needed to be more consistent with discipline.

Tran, his sisters, and mother live with her parents who also believe that as Tran is a boy, he will talk later, especially because he has two sisters who are more than willing to speak for him. His mother feels there is something more going on and has decided to seek help from the local Child Health Service (who subsequently referred to CAMHs), after her friend told her that they had helped them find a special education classroom for their pre-schooler with a developmental delay.

You observe Tran and are concerned that he does not use any words and wanders around the clinic room without purpose. You want to complete an M-CHAT with the family but do
Mrs Buivan endorses three critical items and you review these with the telephone interpreter who confirms that these are accurate responses. You revisit Mrs Buivan’s concerns and support her sense that Tran needs a more detailed evaluation which she requests you help arrange at a follow up appointment. You also encourage her to enrol Tran at a pre-school since at age three; he is eligible for subsidised pre-school education.

Discussion:

Engaging with the family

- Call to remind the parents when and why the assessment will be done.
- Discuss the family’s comfort with speaking and understanding English and offer an interpreter to assist at all visits, making sure that the family understands that the interpreter will protect their privacy and confidentiality.
- Schedule a follow up visit for one or two weeks after the assessment to talk through what happened at the visit.
- Reinforce that assessment is part of standard care since the concepts of screening, early identification and early intervention may be unfamiliar for families from diverse backgrounds. For many families, these concepts are culturally bound and they may perceive that their children will be stigmatised in their communities by participating in these practices.
- In some cultures, the word “assessment” or “evaluation” may be met with mistrust. Take time to explain.

Ask parents

- What is causing the most concern now?
- What kind of things do you think would help your child develop these areas (such as: language, play skills, social engagement, etc.)?
- Did they have Early Intervention in your country?
- What would happen there to kids whose development was behind?
- What do you think is causing these concerns?
- What would you like to happen as a result of this visit?

How best can you support the parents towards accepting early intervention?

- A parent may not respond immediately to your offer of early intervention and specialist evaluation. Some may need several more visits to get to the point of understanding and readiness necessary to enable further assessment and treatment.
- Providing written information in the family’s language will give them an opportunity to
process what you have said in their own time frame. (see http://www.maactearly.org/translated-materials.html)
• Following up with an interpreter or with staff from the family’s culture may provide another level of support as well.
• If you or the child’s family has persistent concerns about development, further evaluation may be needed.

Case Study 3: Attention deficit hyperactivity disorder (ADHD) (Chinese)
(Adapted from Young, 2012)

Jing is a sixteen year old Chinese adolescent. She was born in China but raised in New Zealand from the age of six. Jing is the only child in her family. She says that her parents are understanding of her ADHD symptoms and do not “push” her to excel, although Jing’s parents are both highly educated with graduate degrees. Her father has a Ph.D. in a science field and her mother has a Master’s degree in Information Technology. Jing does not indicate that her parents benchmark her success by the use of social comparison with others. Jing attends her local secondary school where she has been a high achiever and was top of her class in maths and science last year. Her aim is to be a doctor. However, recently her grades have dropped. Socially, Jing doesn’t feel that she “fits in” at school. She has a reputation for being a “space cadet,” and she is still somewhat aloof from others, having few friends (none of whom are of Asian descent). Jing considers herself to be “strange” in high school. She feels alone and different from others. Recently, she has had problems focusing on, and staying interested in her studies.

This year Jing came across her ADHD diagnosis by accident. While surfing the internet, she came across an ADHD checklist of symptoms as a method of self-assessment. She was able to endorse most if not all the criteria for ADHD on the self-assessment. Jing provided the self-assessment inventory to her friend so that she could rate Jing. The friend’s assessment results were similar to those obtained by Jing. This provided Jing with the necessary data to approach her parents about her findings. Jing’s parents initially responded in a supportive way. Her parents “always knew something was wrong with” her. Jing’s parents sought the help of CAMHS to address her ADHD symptoms, namely, medication therapy. However, despite their initial support, Jing’s parents eventually stopped her medication therapy due to the possible side effects she was experiencing, including feeling slowed down in her thinking. As well, Jing’s parents do not believe in mental health care, which may also account for their discontinuing psycho-pharmacological intervention. Jing quotes her parents as saying that ADHD “doesn’t exist in China, it was made up just to sell drugs in western countries.” As Jing
is their only child, her parents want to provide her with the best opportunity to perform well academically and hence they were initially open to allowing Jing to be given medication therapy, despite being dubious about the applicability of the ADHD label to Chinese people.

Since stopping medication Jing’s condition appears to have “spilled over” beyond her academic pursuits to affect her daily routines and personal relationships. Jing reports that she has lost her house keys on several occasions and has also lost her cellphone five times. She loses track of time. She talks about having difficulty successfully interpreting social cues, such as those expressed non-verbally. Jing often forgets to do her household chores, such as emptying rubbish and tidying up after herself. This lack of consideration irritates her parents.

Jing says that she doesn’t know if she really believes in mental illness or ADHD. “I haven’t talked to anyone about it really. I just thought it was how I was. I’m strange. The medication made me feel really slow and I thought, ‘boy is this how normal people feel?’” Since stopping medication Jing says that she struggles to get out of bed some days. She has difficulty focusing on her school work and says that she is being lazy. Jing reports that the medications were effective in allowing her to focus more as it “slowed her down” and made her feel “normal”.

Neither Jing nor her parents have talked to her school teachers for fear of “losing face”, and of being perceived as being lazy and making excuses for her lack of achievement of recent times.

Jing is not currently in any treatment service. She acknowledges that she was performing better academically when she was taking medication than she is now without medication therapy. Jing is considering going back to CAMHS to restart her medication. She acknowledges her parents’ beliefs regarding medication, but wants to consent to treatment services on her own. Jing is willing to do anything that she thinks will assist her in performing academically.

Question 1: What steps are important in engaging with Jing’s parents?

Question 2: What approach and information may help Jing and her parents to better understand ADHD?

Refer to the Attention Deficit Hyperactivity Disorder (ADHD) Section.

Discussion:

- Where possible, cultural matching of clients and therapists may improve treatment adherence and outcome.
- Explain to Jing’s parents that stimulant medications have been shown to improve academic performance, improve interaction with teachers, friends and family, and can decrease their daughter’s anxiety.
- The use of multimodal therapy (i.e. integrating pharmacotherapy with educational and...
psychotherapeutic approaches) can maximise the chances of long-term adjustment.

- Educating Jing and her parents about her disorder and its effects is an important part of the treatment process. Providing client education can help them develop an understanding of how attention, memory, and learning processes work and enhance their learning and academic performance.
- When practitioners are working with children and young people from CALD groups with ADHD who are receiving pharmacological treatment, it may be beneficial to closely monitor their behaviour and mental and physical health. Doing so may, help catch any harmful side effects early so that adjustments can be made, and avoid parental disengagement with treatment.

Case Study 4: Internet game addiction (Korean)
(Adapted from Lee, 2011).

Jin Soo, a 16-year-old Korean adolescent was referred to Child and Adolescent Mental Health Service (CAMHS) by his mother because of his negative attitude, depression, and overuse of the internet. Even though he did not want to emigrate from Korea to a Western country to study, his parents persuaded him to move with his mother and brother. He migrated to New Zealand 4 years ago and had difficulty speaking English. He withdrew from his friends. Jin Soo started playing internet games at the age of seven. Since moving to New Zealand, he spends many more hours playing games because he spends so much time alone.

For Koreans respect between older and younger generations is very important. While Westerners refer to another as “you” regardless of age and status, Koreans use different pronouns to address those who are older which indicate respect. Jin Soo has poor social relationships with his brother and with Korean seniors because he does not use the respectful forms of address. Jin Soo’s mother was concerned about his negative attitude towards his father. For example, when his father visited him from Korea, and suggested doing something together, Jin Soo was negative.

Jin Soo wanted to reduce the hours of using internet games. He spent 3 to 5 hours on playing games on weekdays and 13 hours on weekends. He said that it was difficult to control, especially on weekends.

THE PROCESS OF INTERVENTION
The counsellor was a European woman. Counselling consisted of five individual sessions that ranged in length from 30 minutes to 1 hour per week. Homework assignments were used to record Jin Soo’s activities and how he spent his time. The counsellor explored the thoughts, emotions, and behaviour that helped him to control his desire to play games. The counsellor
and Jin Soo discussed how to manage his time during the week and stickers were used as a reward when he kept his promise.

**Behaviour Modification**
The first session focused on obtaining a general assessment. The second session focused on the assessment of game addiction and creating a contract for behaviour modification. Jin Soo agreed to try to reduce the time spent on games and to increase the time spent on other healthy activities. His mother promised to give him half the money he needed for a new computer if he reached his goal.

The contract was in written form and signed by Jin Soo, his mother, and a counsellor. Also, Jin Soo was asked to record the time he spent on games and alternative activities on paper. In the third session, his mother said that he had decreased his game-playing time but showed agitation because of reducing the time spent on games. He spent less than 1 hour per a day on weekdays, but spent over 3 hours per day during the weekend. He had little to occupy himself on weekends. He tried to talk with his mother and watched television dramas instead of playing games. In the fourth session, he reached his goal for only 2 days. He said that he woke up early, did homework, fared well in his exam, and exercised. He skipped two sessions because he slept late in the morning. His mother said that he sat up all night hanging out with his friends. In the fifth session, he did not reach his goal for even 1 day. He spent over 3 hours on games every day, but he tried to spend time on basketball, talking, and bowing with friends. He explained that he did not come the last 2 weeks because he thought it was too much trouble and it was too far to travel to CAMHS. When he was asked whether he wanted to continue with counselling, Jin Soo avoided giving a direct answer. He was given 1 week to think about this. After contacting the counsellor, finally he said that he wanted to give up.

**Cognitive-Behavioural Therapy**
Jin Soo was encouraged to be conscious that he was spending more time on games, than he intended to and to explain which emotions, thoughts, and behaviours contributed to his overuse of games. He was encouraged to think about which factors were helpful in reducing time spent on games. Jin Soo was asked to record his thoughts, emotions, and behaviours related to games on a form each week. In the second session, discussion focused on the reasons for spending time on games, the disadvantages of playing games, methods to use to decrease time spent on games, and how to improve his overall health. Jin Soo said he played online games because it was fun; he could meet people through online games, and feel satisfaction when he reached the goals of game scores. He wanted to reduce time on computer games because it interfered with his study and was not good for his health. In the third session, a screening tool for measuring his game addiction was given because he did not accept that he was addicted to computer games. He thought that if he wanted to, he could stop. He was encouraged to express emotions, thoughts, and behaviours related to
games. He always felt bored at home. When he felt bored, he usually played computer games. He could not drive. His mother and brother were usually away from home until the evening or late at night and he was often alone on weekdays. Loneliness contributed to his game addiction. In the fourth session, he forgot to bring his homework. He expressed feeling burdened by doing his counselling homework. The idea of cognitive-behavioural therapy was good, but it was difficult for him to practice daily. As time went by, he had difficulty accurately writing down his exact hours on different activities. Additionally, he was asked to record weekly (1) his activities and time, (2) his emotions, thoughts, and behaviours related to games. It was difficult for him to keep the records and bring them to the sessions. The main issue for Jin Soo was managing his boredom. It was suggested that he do something different with his time. After the fifth session, he started to learn golf and he was becoming more interested in golfing. This meant that he reduced the time he spent on games. He and his mother were encouraged to spend time outside the house doing something together such as playing golf.

12-Step Programme
The questions for each session were based on the 12-step programme (On-line game anonymous, 2006). For example, the goal of the first session was “we admitted we were powerless over on-line gaming and that our lives have become unmanageable”. The counsellor offered three questions to approach this goal. “Which part is difficult for you to control?”, “Which part is easy for you to control?” and “Have you despaired about your failure of self-control?” Jin Soo doubted the existence of God because he prayed for something but God did not answer. Therefore he doubted God could help with his problems. He did not feel the need to pray. In the fourth session, what harm he caused to others was discussed. He said that he often lied in online games to sell his items at a high price. He said that he used abusive words because his friend used those words. He said he would try to reduce the abusive words he used. He was encouraged to apologise to the people he harmed through lying and using abusive words. In the fifth session, demerits in his character were discussed. He said that he had difficulty accepting authority figures, often used abusive language, had perfectionism, and played games excessively. He thought that his perfectionism contributed to game addiction because he made a goal for game scores and he wanted to reach the goal. He was encouraged to think about the reasons he had difficulty having relationships with older people. He knew that he should use respectful language and manners when he met Koreans but he said that he did not want to behave differently towards Westerners and Koreans. It felt to him like having a dual personality. His counsellor empathised with the difficulty of living with the expectations of two cultures. He was encouraged to think about other’s perspectives. To have a good relationship with others, his counsellor explained the need to act differently according to different cultural norms.

Result of the intervention
The programme consisted of eight sessions originally. However, the counselling stopped
after five sessions. During the counselling, there was some improvement. However, Jin Soo did not do his homework and did not keep his promise to reduce game hours. In the 2-month follow-up, his mother said that he had reduced his game time since he had started golfing with her.

**Question 1:** Was this a culturally appropriate intervention?

**Question 2:** What could the therapist have done differently to keep Jin Soo engaged in counselling?

**Question 3:** How could Jin Soo’s parents have been engaged in the intervention?

*Refer to the Internet Game Addiction Section.*

**Discussion:**

- Jin Soo may have engaged more with a counsellor who was from a similar cultural background and was male.
- Family intervention is needed to treat Internet addiction in adolescents. Parenting attitudes, family communication, family cohesion, and family violence exposure are associated with Internet addiction. In this case, there was a lack of communication between Jin Soo and his parents. Education and counselling for his mother (and father when available) is important. For example, parents need to know how to have healthy communication with their teenagers, have regular communication with them and encourage healthy outdoor activities (Park et al., 2008).
- The burden of homework in cognitive-behaviour therapy may have caused Jin Soo to stop participation in counselling. To increase participation, the therapist could assign homework one day per week. Providing a folder for record-keeping would help Jin Soo to remember to bring the homework to the session.
- For the best results from counselling interventions for internet game addiction, group therapy is likely to be more successful than individual psychotherapy as adolescents tend to prefer to be in group settings where they can form friendships. The main reason for Jin Soo stopping the counselling sessions may have been that he was not having fun with others of his own age. He had previously had group therapy for ten sessions and had wanted to continue but the group had finished. Addiction recovery is challenging and longer term intervention may be required.
Case Study 5: Bulimia (Korean)
(Adapted from Smart, 2009).

Jae Eun a 16 year old girl has reluctantly sought treatment with the ED clinic, saying that she is feeling hopeless about her weight. She has been binge eating a couple of times a week for over two years and has gained over 6 kgs over this time. She is distressed that her bingeing has increased and has begun vomiting in secret. In tears, she says “I have so much going for me and my whole family is upset that I can’t control myself”, “It’s not their fault though. They just want the best for me”.

Jae Eun is a 1.5 generation Korean who migrated from Korea with her parents as a one-year old. She is doing well at school and is top of her class in maths. Jae Eun plans to go to university and to major in Maths. Her parents run a successful Sushi café chain. Jae Eun considers herself a “Koiwi” (part Korean and part New Zealander). She tells the therapist that her parents are “more Korean and really conservative”.

Jae Eun attributes her body dissatisfaction to her first ever visit to Korea at age 14, saying that the girls and young women there were consumed with fashion and slimness. She is now considering getting eye surgery popular in Korea (to make her eyes rounder). She says that she is “huge” compared to her Korean friends in New Zealand and in Korea, and even though she has excelled in nearly every other area, her parents are “concerned about her future”, which she says means that they are concerned about her finding the best possible husband. She says that she has an “athletic” build and that she enjoys sports and likes the feeling of strength in her body. However, she considers herself “bulky” and “unfeminine”. She says, “I’m a pretty girl and I’m ruining the whole package because I can’t control myself”. Jae Eun’s parents have agreed to therapy with the encouragement of their GP. Her mother tells friends that she is going for weight-loss treatment.

Some initial cultural considerations in using CBT-E in this case (Smart, 2009):
• The time-limited nature and solution-focused structure: likely to be acceptable to both the client and her parents.
• Inclusion of significant others: might be useful, but consideration must be given to issues of stigma and shame, as well as hierarchy in the family system.
• Approach to therapeutic relationship: empathic but authoritative qualities would likely be helpful, but dealing with the potential for premature termination may require cultural accommodation
• Personalised formulation of what maintains the ED: potentially less stigmatising than focusing on what caused the ED, but assessment is needed as to whether the linear rationale fits with Jae Eun’s belief system (and possibly with the family’s belief system).
There is the need for awareness of how culture and gender influence the maintaining mechanisms.

- Examination of the overevaluation of shape and weight: will likely require attention to gender and culture (eg intergenerational cultural differences – See the Assessing Migrant and Refugee Children and Adolescents section), and possibly to internalised racism. Exploration is needed as to whether there is a connection between the need for eye surgery and ED
- Possible use of the expanded form of the treatment: would allow for more work with the cultural influences on perfectionism, self-esteem, and interpersonal relationships. (See Fairburn (2008; 2008a) for a full description of the treatment - http://www.credo-oxford.com/4.1.html).

Excerpts of the therapy process with the client

The therapist is a European woman in her early 40s. Following the initial assessment process, she meets with Jae Eun (who brings her older sister to this one meeting) to describe CBT-E. Jae Eun appears anxious about the strong behavioural focus of the first month. However, she understands the logic that binging and vomiting is not helping her to control her weight, and she agrees to “try anything”. He sister agrees to explain things to their parents.

Jae Eun and the therapist work together on a tentative formulation of maintaining mechanisms related to her binging and purging. Jae Eun makes the following connections: (a) “I am letting down my family by being at this weight” and “I don’t like my eyes” (overvaluation of weight and shape); (b) “Restricting makes me feel better temporarily but then I binge”; (c) “When I am criticised or don’t do well at something, I feel very guilty, which also makes me binge”; (d) Bingeing makes me want to vomit”; and (e) “Vomiting creates more guilt, and sometimes leads to more binging and restricting”.

- The therapist initially tries to encourage Jae Eun rephrase the overvaluation of weight to reflect just her feelings, but suspects that she is missing the meaning of the client’s experience due to her own individualistic value system.
- Including the family in the formulation seems to be a necessary cultural accommodation, and the therapist works to understand that Jae Eun views her weight not as her own, but as a reflection on the family.
- Although Jae Eun readily grasps the logic of the formulation, looking at it presented in a written form upsets her and she cries. She feels very hurt by her mother’s frequent criticisms of her weight and she hates the comparisons made with her “perfect” sister. Jae Eun works hard to stop crying and is very embarrassed by her outburst. The therapist reflects gently how difficult the process is, and keeps in mind that cultural values of emotional restraint and protecting the family will be influencing Jae Eun’s responses.
- CBT-E attends carefully to the client’s ambivalence, and the therapist asks Jae Eun directly how she feels about the process of therapy. Jae Eun says “it’s fine” but will not
elaborate. There is no indication of therapist self-disclosure in Fairburn’s (2008) text, but a cultural accommodation may be useful. The therapist says to Jae Eun: “You’ve mentioned the pressure from your family a number of times, as well as how much you love and value them, and I want to be sensitive to that as we proceed. I’m aware that we’re from different cultures, and we might have some different ideas about families and women’s roles based on that. It seems like it might also be hard to tell someone like me if there’s anything you don’t agree with or have questions about in the treatment.”

Jae Eun responds with “No, it’s okay” at the time, later she stated that she appreciated the therapist’s effort.

• Jae Eun engages actively in learning regular eating and in doing the homework assigned from Fairburn’s (1995) book, Overcoming Binge Eating. They go over Jae Eun’s reactions to the readings by looking at what she has marked in the margins of the book. Two adaptations to this exercise were made. The therapist made an effort to learn about Korean food, which was mostly what Jae Eun ate at home and around which a number of her food battles occurred. In addition, Jae Eun was asked to track the cultural dilemmas and influences that occurred as she tried to follow the recommendations in the book. For example, Jae Eun felt that she could not set limits on the amount of food her mother and relatives gave her. Although similar struggles occur for clients across cultures, the therapist realises that it is exceptionally hard for Jae Eun to challenge her parents, given traditional values of filial piety and hierarchy in the family. The therapist asks Jae Eun if she could bring her mother for a session or two, where she could provide some education about EDs and the treatment. But Jae Eun is sure that this would offend her parent and create more problems.

• As the first phase of treatment is ending, it is clear that this is not working optimally. Jae Eun has altered some of her behaviours, and is externally compliant, but her mind set remains completely fixed. Her tears continue as do her statements that she is letting down the family. Jae Eun and the therapist go back through the formulation and talk about what barriers are keeping the treatment from working. Jae Eun finally states that she is very sensitive to her mother’s criticisms but has also become increasingly fearful of disappointing anyone, and believes that letting family and friends know who she really is or what she feels would be entirely unacceptable. She also admits that she wants to go out with a European guy she knows and that in future she wants some sexual experience before she gets married, but that such activities would have to be kept secret. To a significant degree, the function of ED within her cultural context appears to be a way for her to express and manage the distress of conflicting values.

• Together, Jae Eun and the therapist decide to add the interpersonal component to the treatment, believing that it will help increase self-esteem as well. Interpersonal Psychotherapy (IPT) is targeted to “grief, interpersonal role disputes, role transitions, and interpersonal role deficits” (Fairburn et al., 2008b, p. 217). In this case, the role disputes and transitions are adapted to address Jae Eun’s developmental stage, her emerging bicultural identity, and the interpersonal difficulties caused in part by the acculturation differences between her and her parents.

• This represents a significant shift in the treatment, as the IPT module is a different
therapy from CBT and is far less solution-focused. Sessions were lengthened, and one half was devoted to IPT and the other to CBT. The IPT module helped Jae Eun identify how certain relational patterns occurred and contributed to her cycles of anger, guilt and shame. It permitted a deeper discussion of how her bicultural identity put her at odds with her parents at times and also led to confusion about her role as a young woman. Jae Eun began to reframe some of her mother’s critical comments: not accepting them, but understanding more about their intent and learning ways to defuse her reactions and conflicts. Although she was committed to honouring her family, she began to question the utility of making physical appearance the only way that she could do that.

- Simultaneously, the CBT portion deepened and Jae Eun was able to explore how her thoughts about her weight and eyes were impacted by sexist and racist notions in Western society. In other words, her mind set began to shift and the behavioural changes she had been adopting started to make more sense to her and take greater hold.

**Question 1:** How was this a culturally appropriate intervention?

**Question 2:** What may have led to a more effective family consultation?

**Question 3:** Which cultural accommodations were successful?

Refer to the Eating Disorders Section.

**Discussion:**
- The case demonstrates how cultural adaptations can be made to evidence-based therapeutic approaches (eg the inclusion of IPT to address Jae Eun’s developmental stage, her emerging bicultural identity, and the interpersonal difficulties caused in part by acculturation differences between her and her parents). More attention could have been given to elements specific to Korean migrants (eg the impact of the immigration experience and subsequent efforts at upward mobility, beauty norms, childrearing practices, religious values).
- Increased awareness and knowledge on the therapist’s part may have led to an effective family consultation.
- The effective cultural accommodations included the incorporation of the client’s collectivist belief system, sensitivity to culturally influenced shame and guilt, exploration of her bicultural identity and intergenerational conflict, and the impact of racism and sexism on body image and self-esteem.
Case Study 6: Anorexia nervosa (Chinese)
(Adapted from Rhodes, 2003)

Sally Wong is a thirteen year old girl admitted to hospital for the first time, with a weight of 32.9kg and a body mass index of 13.82. She was medically compromised with bradycardia (slow heart rate), hypothermia, and protein calorie malnutrition, including muscle wasting and poor peripheral blood flow. She was admitted for a total of eight weeks and commenced on overnight nasogastric feeds and a supervised menu plan during the day. She remained on bed rest for the first three weeks, and after five weeks graduated to supervised menu plan only. She attended the hospital school during her admission, as well as physiotherapy, and recreational group programmes. Family and individual meetings in the hospital were limited to diagnostic screening, psychoeducation, and general support. These in-patient meetings were not conducted by the therapist responsible for her outpatient family therapy. Sally’s discharge weight was 35.8kg. Sally’s family consists of her father, Winston, who works as a caretaker, her mother Leanne, who works parttime as a secretary, and her brother Michael, who is eight years old. The family is of mainland Chinese origin and immigrated to New Zealand thirteen years ago.

The therapist’s first contact with the family was by telephone. The therapist introduced himself and explained his role as helping them with Sally’s recovery once she was discharged from hospital. The family was then sent a short letter that reiterated points from the telephone conversation.

Dear Mr and Mrs Wong,

It was good to speak with you yesterday on the telephone to make an appointment for our first family meeting to help you with Sally who is suffering from Anorexia Nervosa. I am particularly concerned about how she will progress once she is discharged from hospital and believe that you will be incredibly important in helping her to return to health. As we discussed, Anorexia Nervosa has the highest mortality rate of any psychiatric illness. We will all need to work extremely hard to make sure that she can recover.

It is very important that every member of your family come to our meetings at the hospital. Each of you will have been affected by the anorexia and each of you will also have something important to offer, in standing up to the grip it has had on the family. It may be difficult at times for all of you to attend, but it is vital given how extremely vulnerable your daughter is at the moment.

I look forward to meeting you all at 1:00 in the Medical Centre. Could you please come
The First Family Meeting

In the first family meeting, the parents described the effect that the anorexia had had on them since its onset six months ago. Both described how distressed they had been by her admission to hospital, but also expressed some relief due to feeling that they had not known how to help her at home. Winston was eager to point out that he felt Leanne was responsible for the severity of Sally’s illness because she had been less prepared to accept the illness than he. Further circular questions revealed that Winston’s criticism of his wife was also related to his own guilt regarding the illness.

Both parents were found to be united in blaming themselves and this was framed by the therapist as one of the anorexia’s manipulative tricks. Further questions were used to extend this process of externalisation to Sally. The anorexia was seen as more in control of Sally than vice versa. The anorexia was described as having been successful in deceiving her into seeing herself as fat, and also at getting her to drink water before her initial weighings at her General Practitioner’s surgery. No exercising was reported. Michael was observed to be actively involved in reporting on Sally’s behaviour, and Sally said that he often did this at home. Sally angrily stated that it had had a negative effect on their relationship. The therapist then summarised the session so far, taking great pains to empathise with the family’s suffering over the past six months.

The family was then asked what effect the anorexia would have on Sally if it continued to take charge over the next twelve months. Winston and Leanne described how her growth might be stunted and how her reproductive system might be damaged. The therapist described other possible medical complications as well as the risk that it could kill her. The family was visibly shocked by this, but the parents still stated that they would do whatever was possible to help her. The session was then summarised and the family was charged with the responsibility of standing up to the illness. The therapist expressed his firm belief that they were the best resource for this purpose. Arrangements were then made for the next session, the family meal.

The Family Meal

This session was held at 12.30 p.m. to coincide with lunchtime. Leanne brought ham sandwiches, fruit, and orange juice from home, and Winston brought a large serve of noodles and vegetables that he had purchased near his workplace. The parents were asked to attempt to get Sally to eat one more mouthful than she wanted to. Sally was also asked to resist their attempts so that they could gain some practice in taking charge of the illness. Michael was asked not to join his parents but to watch out for any signs of distress in Sally.
During the early stages of the meal, the therapist asked the family questions about eating habits at home. Sally and Michael typically ate breakfast on their own, while Leanne made school lunches and Winston got ready for work. Winston was rarely present for dinner, but the remaining family members sat together. Sally was reported to eat the same food as the rest of the family, but in smaller quantities. Further questions, however, revealed that Sally often ate chicken when the others ate red meat.

Leanne had also taken to buying low fat milk and yoghurt instead of full fat dairy products. The parents were asked to consult their instincts about the kind and quantity of food that Sally would need to eat to gain a healthy weight. They both felt that she should be eating high fat dairy products and red meat, and should also be eating the same size servings as the rest of the family. At this point in the interview Sally had finished her sandwich and juice but stated that she did not want any fruit. Winston then proceeded to lean across Michael’s seat to ask Sally to try some noodles. The therapist asked Michael to move so that Winston and Leanne were sitting on either side of Sally. Winston was persistent in his requests, which was praised by the therapist. Sally became angry after the fourth request, telling him curtly to change seats again. The therapist then asked Michael to guess what effect his father’s attempts were having on Sally. He said she was angry because she would feel her father was hassling her. He also felt that she did not like being hassled in front of the therapist, whom she did not know very well. Sally agreed with these guesses and her anger seemed to settle. Winston and Leanne were then asked to continue standing up to the illness.

This process continued for twenty more minutes. On one occasion Leanne started to negotiate with Sally about the caloric content of the noodles. The therapist then asked Leanne if she had done this before and how effective it had been. She was encouraged to continue the monotonous requests with her husband. At 1.25 p.m. Sally asked the therapist if she had to eat a lot or only one taste. The therapist referred this question to the parents who indicated that she only had to have one mouthful. Sally then proceeded to eat this just in time for the end of the session. The family were congratulated on their success, but agreed that this process might be a lot harder at home. They agreed to eat their breakfast together, and Winston said that he would arrange with his work to be home for dinner two week nights per week.

**Continued Focus on the Refeeding Process**

The remainder of Phase I took nine weekly sessions. In this time Sally’s weight rose to 40.5kg, with no weight gain in the first two weeks and a decrease of 500g on week five. In the first two weeks, the parents had been successful in introducing high fat dairy products, but Sally had compensated by 30-minute daily periods of exercising in her room. The parents then agreed to stand up to this behaviour and developed a joint strategy of checking on her every five minutes when she was in her room. The therapist was careful to reinforce their
success with dairy products, and their team approach to exercising. Michael had some difficulty forming an alliance with Sally in this first two-week period and was tempted on numerous occasions to join the parenting team in their refeeding task. Sally said this made her feel like everyone in the family was against her.

Winston and Leanne decided to help Michael by reminding him when he attempted to join them. From this point on, Winston and Leanne progressed well with the refeeding task. Michael also improved in his attempts to form an alliance with Sally. They had little success with getting Sally to eat red meat, but increased her intake of chicken and pork instead. They were gradually able to increase the amount of food she ate at each meal. Their main strategy was to insist monotonously, but they also developed more creative approaches. One strategy was to remind Sally how much she had disliked her stay in hospital. Another was to name anorexia ‘Annie’ and remind her jokingly when it was bossing her around. One two occasions Leanne became angry with Sally during refeeding when Winston was not home at dinnertime. Winston decided to call Leanne on the nights when he could not be home, to support her in the refeeding process. The family expressed some disappointment at week five when Sally lost 500g. The father requested that the therapist focus on telling his wife that she was responsible and stated that Leanne and Sally were both as stubborn as each other. He wondered if family relationships could be a focus of the therapy rather than simply concentrating on food. The therapist was very clear in pointing out the dangers of concentrating on issues that were not directly related to eating, given that Sally was still at serious medical risk. Further exploration of the events of this week revealed that Winston had worked very long hours due to the absence of his manager and that he had been quite critical of his wife upon his return home. This was again reframed as a product of his own concern for Sally, and as an attempt by the illness to split them up as a parenting team. The therapist revisited the collapsing time strategy from the first session, asking the parents about what might happen to Sally if the anorexia continued to be successful in this way. Careful plans were put in place to take back this ground from the illness. The father agreed to come home for dinner for the next week and both parents would follow strategies that had already worked in the past five weeks.

**Phase II: Negotiating for a New Relationship**

At week ten, the therapist and the parents decided to move to Phase II of treatment. The parents felt that Sally was well on her way to recovery, and expressed some relief that they had been able to take charge of the illness. They both felt comfortable with gradually handing some responsibility back to Sally. A two-week experiment was set up for Sally to eat breakfast for two days per week without her mother or father present. Her parents also allowed her to go on a day trip with a group of girl friends and planned carefully which foods she would buy and eat. Within two weeks Sally had gained another 1kg and reported menstrual spotting. The parents also reported that they no longer needed to remind her to eat. The family was now eligible for the commencement of Phase III.
**Phase III: Adolescent Issues and Termination**

The main adolescent concerns raised by Sally and her family involved conflict regarding Sally’s choice of social activities. Her parents were keen for her to become involved in a Chinese church and to join the youth group with other Chinese adolescents. Sally was more interested in socialising with adolescents from school from a variety of cultural backgrounds. The therapist was initially concerned that marital tensions might also be raised, due to Winston’s tendency to blame Leanne for the anorexia, but this was not the case. The therapist assumed that some degree of harmony between the couple had been achieved indirectly by the facilitation of a stronger parenting alliance. The parents and Sally were then asked to try and solve in the session the problem of Sally’s friends. They were encouraged to see this tension as a normal part of the life cycle for families from different cultural backgrounds and to find a win/win solution. Sally agreed to attend the church with her parents but not the youth group. The parents agreed to allow her to go out on the weekend with friends from school so long as they had met them beforehand. No further questions were raised. The family was seen on two more occasions over a twomonth period. The adolescent issue regarding Sally’s friends was resolved without the need for more intensive family therapy and Sally reached a weight of 41.9kg. Treatment was closed by asking the family to review their progress over the 21 weeks of treatment. The therapist expressed his confidence that they would succeed in the future if any problems arose and each family member was given an opportunity to say goodbye.

**Question:** What factors will need to be addressed in regards to successfully engaging with Sally’s parents over the course of the intervention?

**Refer to the Eating Disorders section.**

**Discussion:**

**Engaging the family**

- This first meeting is of crucial importance in engaging with CALD families. It is important for clinicians/therapists to establish their roles and credentials. It may take 3-4 sessions to establish trust and rapport with the family.
- It will be helpful, where possible to use culture/language matched clinicians and therapists.
- It is important to establish who the family decision-maker, and care-taker/s are and to ensure that they are informed and consulted.
- Adopting a directive approach towards mobilising the parents’ sense of responsibility for refeeding their child will be more culturally acceptable.
- Where English is a second language, the use of a (preferably mental health trained) professional interpreter is important. Written communication may need to be translated. Be aware that the gender of and choice of interpreter may be important for families.
Psychoeducation:

- The first step is to employ circular questions to explore the effects of ‘the anorexia’. Family members can be encouraged to argue against the parent-blaming view that is held by the illness. The therapist also encourages the family to separate the patient from the illness by stressing how little control the patient has over these behaviours, and how it has gradually overtaken her.
- Features of anorexia, such as distorted concepts of body image, food-related anxiety, and water-loading before weigh-ins may also be framed as ‘tricks that the anorexia has gradually employed’ to take control of the patient.
- The technique of collapsing time (White, 1986) is then used to create an intense scene regarding the possible medical effects of prolonged illness. This is an important focus, given that anorexia has the highest mortality rate of any psychiatric illness at 6–15% (Steinhausen et al., 1991; 1993). There are also risks of permanent growth retardation, osteoporosis, cardiac dysfunction, and structural abnormalities in the brain (Fischer et al., 1995).
- The parents are then encouraged to take two weeks off work to start the refeeding process, and the adolescent is asked to take two weeks off school. The message the parents are left with can be summarised as ‘It is definitely not your fault, but it must be your responsibility’.
- It is helpful to normalise intergenerational conflict between young people and parents as a common experience in migrant families, as parents/grandparents may feel that they alone are encountering these issues.

Case Study 7: Post-traumatic stress disorder (PTSD) (Somali)
(Adapted from Ministry of Education, 2007).

Mohammed is a ten year old Somali boy from a refugee background who presents with severe outbursts of violent behaviour at school, and extended periods of isolation and withdrawal. Mohammed copes poorly with his anxiety about being away from his mother while at school. He abruptly leaves the classroom and calls his mother who collects him whenever he becomes anxious. Mohammed avoids school whenever possible, missing as many as 20 days a term. While at school, he is unsettled, attention seeking, aggressive with other children and unable to concentrate and to stay on task in the classroom. He is unable to form positive relationships with his peers. He is the only Somali child in his class. Mohammed is referred to the Child and Adolescent Mental Health Service (CAMHS) after a critical incident at the school, which is the latest of an on-going series of issues the school has experienced with this child.
Family history
Mohammed’s mother Zahra is a solo mother. Mohammed has a younger sister Deeqa who is eight years old. The family fled to a refugee camp in Kenya when Zahra’s husband was killed during the civil war. Zahra is using the parenting techniques which are used in Somali culture but these are ineffective in the New Zealand context. The children have no routines or boundaries and the discipline used to control them is ineffective. The family have a range of psychosocial stressors which are impacting on Mohammed’s behaviour and his mental health including: living a long way from the school with no transport; having inadequate means of support and not enough clothing and bedding. Zahra is suffering from depression and posttraumatic stress disorder related to the family’s traumatic refugee experiences and to social isolation in New Zealand. Mohammed and his sister’s English is developing but their mother speaks very little English.

The Initial Engagement and Assessment
The CAMHS team’s initial process of engagement requires more time than it would usually take to build trust and rapport with the family. This happens with the assistance of a cultural adviser who speaks Somali. Zahra gives informed consent to proceed with an assessment and intervention. Engagement activities include:
• Talking to school staff (including teachers and counsellors).
• Observation of Mohammed at school and at home.
• Interviewing Mohammed, his mother and sister.
• Assessing mental health, trauma and other issues using standardised tests that are culturally appropriate for the context as well as discussions with family members.
• Consultation with CYFs regarding any care and protection issues.
• Multiagency meetings and review meetings to discuss the case.

Analysis and Intervention Planning
In the assessment and analysis phase the following issues are considered for the child and the family:
• Predisposing factors eg past trauma.
• Precipitating factors eg antecedents/ existing stressors.
• Perpetuating factors eg reinforcing consequences.
• Preventative factors eg resilience, strengths, support systems.
Analysis of this information provides a framework for organising interventions. A coordinated, culturally appropriate/intersectoral intervention plan sets achievable goals for Mohammed and his family.

Coordinated intervention plan
• It is evident that Zahra is not coping with the many ongoing stressors she faces. The social worker arranges respite care for her and arranges for the children to be placed with extended family in her community.
• The children are monitored both at school and in their temporary placement during this
period.

- The CAMHS therapist works with an educational psychologist who coordinates a ‘managing difficult times’ strategy at Mohammed’s school to respond to his outbursts of violent behaviour.
- When Zahra improves she returns home and is provided with further support from the social worker.
- The family advocates to Housing New Zealand for the family to be re-housed closer to the school, and accesses warm clothing and bedding for the family.
- An intervention plan to deal with the behavioural and mental health issues is then developed with Zahra and the children, addressing the most pressing issues first.

Clarifying and Responding

- The clinical case worker introduces play therapy as a medium to help identify and reduce Mohammed’s anxiety. The clinical and education case workers collaboratively develop a number of coping interventions for him to deal more effectively with his anxiety in school and home environments. These include curriculum adaptation at school, techniques of positive visualisation and arousal reduction techniques.
- Mohammed is encouraged to delay contact with his mother until school break times rather than leaving the classroom mid-lesson.
- Mohammed has a number of one-to-one counselling sessions to begin working with his past trauma and his overwhelming feelings of anxiety.

Improving parenting skills

- The CAMHS and education case workers establish a behaviour modification programme to be run concurrently by Mohammed’s mother at home and by his teacher at school.
- In this programme, Mohammed is rewarded on a decreasing reinforcement regime to stay at school for an increasing number of days. Rewards include computer time in the classroom and a favourite weekend activity.
- Work with Zahra involves discussions to increase her understanding of her role in colluding with her son in his absences from school.
- Zahra is taught effective ways to manage Mohammed’s bedwetting and how to use more effective parenting methods. As a result of this, the bedwetting stops and bedtime and homework routines are established for both children. Zahra and the children report that they feel more rested and less stressed as a result of the changes.
- Both the education and CAMHS case workers undertake a series of family and one-to-one therapy sessions with the family to help them deal with the trauma they have previously experienced. As a result Zahra and the children are better equipped to talk to each other about things that bother them. They report that they are starting to have conversations about real issues and are beginning to understand each other’s viewpoint better.

The School Context

- Mohammed’s school provides a school counsellor when he is feeling anxious and
unsettled. The education case worker works with the staff to help them understand the issues faced by refugee families and how these might impact on behaviour at school.

- The education case worker develops, in collaboration with the school, a specific social programme for Mohammed based on his skills and interests, to help his socialisation and to reduce his anxiety.
- As part of the intervention, a sports team is formed in which Mohammed plays a prominent role. This provides opportunities for him to improve his social standing with his peers as well as teaching him about team work, sharing and taking turns.
- The education case worker also works with Mohammed to improve his learning skills through exercises such as mnemonic techniques.

Positive Outcomes Identified

- As a result, the school report that Mohammed’s absences have dramatically decreased to four days per term and that Mohammed is using the strategies to deal with his anxiety well.
- Mohammed reports that he is feeling less depressed.
- He is using his newly acquired academic techniques to improve his concentration at school and is more engaged with his schoolwork. Although Mohammed’s academic results have not significantly improved, staff comment on how noticeably relaxed he now seems to be and his marked improvement in his command of English.
- As a result of his social programme, he excels at a sport, increases his confidence and develops better social skills. In using those skills, he makes friends at school and reports that he feels less isolated from his peers.
- Incidents where his behaviour is inappropriate decrease and school staff feel more positive about Mohammed.
- Zahra experiences more confidence in approaching the school about any problems. She also reports feeling less stressed and is motivated to attend English language classes for herself. This not only improves her language skills but also provides an opportunity for her to socialise and, as a result, she feels less isolated. She starts thinking about employment options. Her son’s behaviour has improved enough for her to venture out into her own community with the children without feeling embarrassed about their behaviour. She reports that this has made her feel more supported.

Question 1: What factors contributed to successful engagement with the family?
Question 2: Why was a multi-agency collaborative approach to intervention important in this case?
Question 3: How do the assessment and intervention processes for this case differ from other cases you work with?
Question 4: How should the complex needs of refugee families and children be addressed in an ecological model?

Refer to the Post-Traumatic Stresss Disorder Section.

Discussion:
• Effective engagement with the family is essential. The engagement process can take much longer with refugee (and other ethnically diverse) families than would be expected with other population groups.

• The assessment process is not a discrete piece of work. It takes time for the family to develop trust with mental health, education and social service providers. Assessment information gathering will often proceed while associated interventions are delivered. The full assessment and complete intervention plan is an on-going developmental process.

• In recognising and understanding the complex needs of this client group, it is important to recognise that sustained change and positive outcomes can take longer to achieve. Interventions must be sustained over a long period of time in order to cement the desired changes.

• The ecological model of intervention for some of these complex presenting issues has been demonstrated to have worked well in the international literature (Potocky-Tripodi, 2002; Miller & Rasco, 2004; Ministry of Education; Shaw, Henderson & Fielding, 2005).

• Gaining trust/engaging with the family is essential in order to gain accurate assessment data and to ensure that the family stay engaged with the services so that sustained support may be achieved.

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**Case Study 8: Psychosis (Muslim)**
(Adapted from Bradby et al., 2007).

Rifat was 13 when first admitted to hospital hearing voices. At that time she ‘did not want any help’ and felt that ‘everybody was against me’, worrying that the hospital was ‘going to keep me over there for ever.’ During the first couple of years Rifat felt very suspicious of her medication, and, particularly when she felt well, she would stop taking it and subsequently symptoms would recur. Rifat says in the past she ‘went hyper’, got very withdrawn or ‘could not think’. She attempted suicide on at least two occasions, and was admitted to hospital as an emergency twice, once against her will, (under section) when legal powers were invoked to impose treatment. Rifat’s mother points out that Rifat is not mad, but does have an illness. Since the family had not met this type of illness before, they were extremely worried and sought help from the Molvi (holy man) at the mosque. Stories of possession by ghosts or djinns (which they now regard as foolish) frightened the family and they put prayers written on fragments of paper (taveez) around Rifat’s neck.

Now aged 16 and attending college, Rifat says she understands the importance of her medicine. Her clinicians describe her condition as stable and appropriately medicated. Rifat’s mother says her daughter is ‘fully recovered now’. Rifat’s mother makes no criticism
of medical staff and their understanding of Rifat’s medical needs, but insists that hospital arrangements were deeply unsuitable for her daughter: Rifat was in a mixed psychiatric ward sleeping next to a young man. No special provision was made for halal food requirements, toilet and hygiene habits or her prayer routine, which, as an observant Muslim, were important elements of daily life.

| Question 1: | What factors are involved in Rifat’s late presentation for mental health care on her first and subsequent admission to hospital? |
| Question 2: | How could the staff caring for Rifat in the inpatient setting have made her care culturally and religiously acceptable to Rifat and her family? |
| Question 3: | How will psycho-education help when explaining Rifat’s illness to her and to her family? |

Refer to the Psychosis Section.

Discussion:

What factors are involved in Rifat’s late presentation for mental health care on her first and subsequent admission to hospital?

Rifat’s parents did not initially recognise their daughter’s psychotic episode as an illness. They say that in their culture (Pakistani) ‘We didn’t know about this type of illness’. The parents sought help from a religious leader and received cultural/religious explanations and remedies for Rifat’s symptoms which were ineffective.

The stigma of mental illness is a major barrier to using mental health services for South Asian families. In the Pakistani community any mental illness is likely to be seen as madness and consequently Rifat’s parents could not allow these things to be spoken about in their family or community. This stigma is connected to the assumed heritability of madness because as Rifat’s mother says ‘it becomes hereditary and comes in the blood.’ She expresses concern that she would be seen as bringing madness into her husband’s family and is at pains to explain that mental illness did not run in her family, and, although she had not known it when she married, it did run in her husband’s family. Rifat’s mother explained that her husband and parents-in-law had kept her husband’s sister’s severe problems a secret from everyone and she had only learned about it through third party gossip. The fact that the in-laws continued to maintain the secret, even after Rifat’s problems became apparent, was worrying her because of the aspersion it cast on her own family’s reputation and therefore the potential damage to the marriage prospects of her children. Rifat’s mother explains that no-one would ever mention a relative’s mental illness, even if it persists for years because in ‘our Asian society ... you don’t say these things’.

The use of mental health services was taken to imply madness in one’s family and this
implication was something that Rifat’s parents wished to avoid. As she says, the reason for
avoiding using mental health services is that ‘our people are closely related in Auckland and
families observe other families’ health’ with a view to evaluating potential marriage
partners. The importance of marriages contracted by family members cannot be under-
estimated for both Muslim and non-Muslim Asian families (Bradby 1999).

When it became difficult for the family to deny Rifat’s mental illness, steps were taken to
minimise gossip. Rifat’s parents describe her illness to others as already fixed by medical
intervention, consigning the illness to the past as ‘cured now.’ Although Rifat has
experienced a number of psychotic episodes requiring inpatient emergency care her
parent’s describe her as ‘recovered’, although her underlying condition is likely to be
ongoing.

**How could the staff caring for Rifat in the inpatient setting have made her care
culturally and religiously acceptable to Rifat and her family?**
Staff could have consulted with Rifat’s parents in regards to her cultural/ spiritual/hygiene
needs eg the provision of a halal diet, a prayer space, gender matched staff (wherever
possible) and of female only sleeping arrangements. The Islamic faith has particular rules
regarding personal hygiene when going to the toilet. Hygiene arrangements include the
availability of a jug of water in toilets to wash the genital area. This washing is known as
*istikla*. 

**How will psycho-education help when explaining Rifat’s illness to her and to her family?**
Rifat’s mother does not speak or read English. The provision of an interpreter who is mental
health interpreting trained and has an understanding of CAMHS and its associated services
will be helpful to the family.

There are no Urdu translations of the information available for parents. Rifat’s mother relies
on her English-speaking sister-in-law to locate and read information on her child’s mental
illness. With Rifat and her parents permission, involve the sister-in-law as a trusted relative
in giving information and psycho-education to the family.

Explain to Rifat’s parents that follow up care will be provided in a community setting (with
an interpreter) and not in a hospital setting associated with mental health (because the
parents state that ‘the word mental in our community is very unacceptable’).

Highlight the experience and expertise of medical professionals and the mental health team,
to foster trust and confidence in the western medical model of mental health care.
Explain that Rifat is not mad and that she has a treatable illness from which she will recover.
With medication, Rifat’s symptoms can be overcome. Explain the importance of taking
medication regularly to her parents in order to maintain Rifat’s stability.
Case Study 10: Family therapy (Indian)
(Adapted from Baptiste, 2005).

Dr Patel and his wife are doctors, an ear, nose, and throat specialist and a GP respectively. Their son Divesh (age 16) was referred for family therapy by a colleague, 10 years after migrating to New Zealand. A younger son (age 12) and a daughter (age 5), complete the family. At interview, the parents, in particular the mother, presented a long and detailed list of Divesh’s transgressions which included: partying on the weekends and staying out later than his parents approved, staying over at a Kiwi friend’s home without parental permission, drinking beer and eating hamburgers (the family was vegetarian), dressing in ways unacceptable to his parents, and most damaging of all, he wanted to study to become a psychologist rather than the doctor his parents expected him to be. According to his mother, Divesh had been a model child until a year ago. She said, “he listened to his parents and did not give us trouble.” All that changed when he joined the school soccer team and began to associate more closely with his Kiwi peers on the teams. His mother attributed Divesh’s behavioural and attitudinal changes to the negative influences of three specific teammates whom she accused of corrupting Divesh such that he had become “more like a Kiwi child than the Indian child they believed they were raising”. Divesh’s mother’s perception of Kiwi children and parents, in particular adolescents and their parents, was very unflattering; she believed herself to be a much better parent than her Kiwi counterparts. As a result of the parental objections, Divesh was withdrawn from the soccer team and many of the freedoms he previously enjoyed were severely curtailed. Divesh’s mother’s displeasure with Kiwi culture intensified when the soccer coach visited the parents to persuade them to allow Divesh to rejoin the team. She concluded that the coach was more interested in Divesh “becoming a soccer player than being a good boy who listens to his parents.” He did not rejoin the team.

Divesh was very critical of his mother. He accused her of, “liking to be in New Zealand for the money but not liking Kiwis”, and “thinking that you are better than everybody and wanting me to be Indian in New Zealand”. From his perspective, the behaviours his mother found objectionable were necessary to “fit in” with his peers. He pointed out that he still maintained very high marks in high school and was a member of the chess and mathematics clubs. Furthermore he did not complain much when his parents, primarily his mother, refused to buy him a car, “even though you can afford it.” Divesh’s father did not say much, but what he said was less intense than his wife. He acknowledged the difficulty of raising children in New Zealand given “the night and day” differences of expectations for children’s behaviours in NZ and India. He also acknowledged that, “Divesh is a good boy” and that “everything was different for all of us.” He solicited the therapist’s assistance to find the family “a workable middle ground.” Accordingly, therapy focused on helping Divesh and his
parents to explore compromises and alternatives to being polarised, within a workable middle ground.

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Refer to the Family Therapy Section.

Discussion:
- Before attempting to effect any changes within the family’s system, it is important that therapists initially communicate to the family an understanding and acceptance of their system and learn about the family’s culture/religion from it, especially family roles, values, and relationships, and how these affect the family’s interpersonal relationships. For example, the importance of a vegetarian diet to Hindu parents.
- It also is important that therapists approach changes to the family’s core values very slowly, and be able to communicate to the family an understanding of the specific issues around which the presenting problem is centred, e.g., the parents’ style of discipline or the child’s outright disrespect of parents. Many of the problems parents and children bring to therapy are the predictable consequences of migration and resettlement in a new country, and the normative separation-individuation of adolescents and young adults from their families of origin. However, under different cultural rules, and with more parental anxieties, and uncertainties than in their countries of origin. Characteristically, these problems often extend beyond the family’s boundaries and are difficult to resolve because both parents and children subtly demand the therapists’ allegiance.
- It is important that therapists assume a neutral stance with both parents and children in the conflict, and be extra careful about condemning, supporting, empathising or aligning with either side. A majority of the problems migrant parents and children bring to therapy are value conflicts between the parents’ Asian values and children’s new “Kiwi” values. Consequently, New Zealand therapists are more likely to ally with the children because of their perceived compatibility with the children’s “Kiwi” values, and condemn the parents with whose values they may have less compatibility. However, such an alignment can exacerbate the already stressful parent-child conflicts and contribute to negative therapeutic consequences such as the family’s early termination of therapy.
- Although any theoretical therapeutic approach can be effective with Indian families, it is important that therapists be flexible in their therapeutic approaches and modify their usual therapeutic approaches with the family. Flexibility must include a willingness to accept the problem in the manner in which the family frames it, to vary the timing of specific interventions with the family, and to incorporate education and information about New Zealand child-rearing practices and normative separation-individuation of children, for example.
• It is important that therapists work with Indian families, especially unacculturated adults, to help them to increase their trust in psychotherapy and its processes. Although significant numbers of Indian migrants are members of health care professions, including mental health, Indian migrants in general maintain a cultural distrust of psychotherapy and as a result, often under utilise such services. Distrust in part results from families’ unfamiliarity with and the minimal availability of psychotherapy in countries of origin as well as the highly developed sense of privacy consistent with their Indian cultural beliefs. This belief stresses the importance of keeping family business within the family not to be disclosed to outsiders including psychotherapists and even GPs and other medical professionals. Accordingly, helping Indian families to decrease their therapeutic defensiveness, and build trust in the therapeutic process can help to relax their heightened need for privacy and engage more fully in the therapeutic process.

• It is helpful in the process of therapy for therapists to broaden the scope of therapy beyond the initial presenting problem(s). Although parent-child intergenerational conflicts may be the primary presenting problem (s), issues of loss may need to be explored for many of the adults. For many adult family members, multiple losses are secondary to the migration as a significant contributor to many of the parent-child conflicts they experience. In this regard, many Indian migrant parents’ high expectations for their children’s educational achievements may be related to the parents’ own frustrations in achieving career or occupational goals and may therefore be related to mental health issues among parents as well.

• Keep interventions direct, active, and focused on a limited number of behavioural changes. Doing so will minimise the parent-child stresses and help the family to return to its pre-therapy equilibrium. As noted previously, many Indian migrant families are unfamiliar with western psychotherapeutic approaches, and seek family therapy only as a last resort, usually at the insistence of a respected relative or friend. Consequently, to engage families in therapy, it is important that therapists not attempt to cover too much ground but keep the more substantive transitional issues in sight.

Case Study 11: Cognitive behavioural therapy (Sudanese)
(Adapted from Friedberg, et al., 2016).

Nico (13) his 19-year-old sister and 24-year-old aunt are refugees from Sudan. Nico developed school refusal a year after arrival in New Zealand. The school was a much larger and more chaotic than the academic environment he experienced in Sudan; Nico also hated the loud bells that rang often throughout the day. He experienced substantial physiological hyperarousal upon arriving on school grounds and hated the way his skin “crawled”. Nico spoke often about his desire to be in a “peaceful” place and reported that the school was so
aversive because it was the “opposite” of peace. When training Nico in breathing exercises, the clinician likened the activity to “breathing in peace, and breathing out chaos.” Pairing Nico’s desire for peace with the behavioural intervention gave him a concrete understanding of how the exercise helped him to achieve his goals.

**Question:** Describe the CBT treatment approach and why it was successful.

*Refer to the Cognitive Behavioural Therapy Section.*

**Discussion:**
The therapist used basic behavioural tasks. Basic behavioural tasks relevant to a client’s presentation are identified by reviewing data collected from the target-monitoring phase. Techniques are designed from classical conditioning, operant conditioning, and social learning theory. Behavioural procedures aim to change overt actions. Through practice of these activities, clients acquire new tools to more effectively cope with distress and change action tendencies associated with heightened emotional arousal. Basic behavioural tasks are particularly relevant to many refugee and migrant youth as somatic symptoms are often predominant with these clients (Kirmayer et al., 2011). For example, the ideal behavioural tasks for a child who reports significant anxiety marked by autonomic hyperarousal and somatic complaints include relaxation techniques. Diaphragmatic breathing or progressive muscle relaxation teaches the patient to interrupt the pattern of physiological hyperarousal. Activities for youth combating depression include pleasant activities scheduling or behavioural activation to mitigate the lethargy induced by depression. These interventions augment sources of positive reinforcement and improve mood. Social skills training, habit reversal training, contingency contracts, and the implementation of reward systems are other available procedures. Basic behavioural tasks actively and explicitly teach the child that he/she is able to exert some control over distressful experiences. Skills gained instil hope, motivate clients to progress in treatment, and pave the way for future interventions (Friedberg, et al., 2016).

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**Case study 12: Cognitive behavioural therapy (Japanese)**
(Adapted from Friedberg, et al., 2016).

Asuka, a 14-year-old Japanese girl, migrated to New Zealand with her parents, brother, and grandparents when she was 10. Asuka was diagnosed with OCD and displayed contamination fears related to “sharing air” with people; she could not talk to others unless she stood several feet away to ensure she breathed “fresh” air. This dramatically interfered with her ability to develop a social support system despite the fact she found a group of girls who shared her passions for anime and manga—animated adventures in video and graphic
novel formats. When she reached the cognitive restructuring module, her therapist suggested that she make her own manga to chronicle her “battles” against the OCD. Asuka delighted in the exercise and created extraordinary pages illustrating her cognitive contests against the OCD villain living in her mind. Not only did this exercise make cognitive interventions literally come alive for Asuka, it also established a way for her to open communication with her friends.

<table>
<thead>
<tr>
<th>Question:</th>
<th>Describe the CBT treatment approach and why it was successful.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to the Cognitive Behavioural Therapy Section.</td>
<td></td>
</tr>
</tbody>
</table>

**Discussion:**
The therapist used cognitive restructuring interventions to target Asuka’s thought content and thought processes. Youth learn to reduce cognitive distortions and train their minds to think more flexibly. Cognitive interventions include problem-solving, reattribution, decatastrophizing, test of evidence, and self-instruction. The use of metaphors related to concrete ideas or the youth’s interests heightens the client’s experience of cognitive interventions (Friedberg, et al., 2016).

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**Case Study 13: Cognitive behavioural therapy (Iraqi)**
(Adapted from Friedberg, et al., 2016).

Aliyah, age 11 is Iraqi; she and her parents left Iraq when she was 3 and moved in with an aunt, uncle, and four cousins in New Zealand. Her parents brought her to therapy for treatment of anger outbursts that occurred solely in the context of school. Upon intake, Aliyah had been suspended twice for fighting. Her parents were so perplexed by her behaviour that they were considering sending her back to live with family in Iraq. Therapy revealed that Aliyah was lashing out at peers physically in response to racially motivated bullying at school. Aliyah lacked the complex language skills to be able to “fight back” with her words.

Aliyah created a hierarchy specific to the behaviours of her peers that “made her explode.” The lower-rated behaviours included people staring at her, pointing, and whispering and then climbed to name-calling and physical contact (eg, pushing her).

After learning skills to use when she “got hot”, Aliyah and her therapist went out into the waiting room wearing different props to attract people’s stares. Aliyah noted that she did not feel as angry when adults looked at her as she did when other youth did. Therefore, to
make the exercise more relevant, Aliyah and her therapist went to sit in a paediatrician’s waiting room.

For the final step, Aliyah and the therapist went into a crowded café close to the clinic to practice how to remain calm when others bumped into her. When they first began this step, Aliyah’s father came to the café with them. Aliyah realised that she felt safe with her father near, stating “he will always take care of me.” Thus, they pursued further practice with no parent nearby. Because the therapist attended closely to the level of emotional activation evoked by the interventions, Aliyah was able to generalise her learning to the school environment and finished the academic year without another fight.

**Question 1:** Describe the CBT treatment approach and why it was successful.

**Question 2:** What suggestions can clinicians make regarding stopping the racial bullying in this case?

Refer to the Cognitive Behavioural Therapy Section.

**Discussion:**

- The therapist used exposures. Aliyah was allowed to engage in exposure to emotionally evocative stimuli and was able to apply the coping skills she learned throughout therapy. This intervention transformed her reactive tendencies and eliminated maladaptive behaviour patterns.
- Founded on the social learning theory, concepts of performance attainment and mastery are the mechanisms through which distress is relieved. Effective exposures must take place in the context of emotional arousal so that the client truly learns how to utilise coping skills in the face of their ultimate stressors.
- Clinicians collaboratively devise exercises where clients face challenging situations identified in the hierarchy from the target-monitoring phase. Exercises begin with situations that elicit a moderate level of discomfort; clients confront the experiences and employ adaptive strategies to either reduce distress or tolerate the uneasiness. If the exposure is executed properly, patients’ fear of the stimulus is diminished. In this fashion, client’s “climb their ladders” as they move through situations ranked as increasingly upsetting. Termination of care is indicated once patients leap these hurdles (Friedberg, et al., 2016).
- Aliyah is being bullied at school and this needs to be addressed. The clinician can encourage Aliyah and her parents to meet with senior staff at the school to discuss the problem and how to address this. All schools have policies to prevent and respond to bullying (see http://www.education.govt.nz/school/student-support/student-wellbeing/health-and-wellbeing-programmes/bullying-prevention-and-response/). When physical assault or cyber bullying are involved, this is a criminal matter and the police may be notified. Every region has ethnic police liaison officers who can be contacted: http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers.
Case Study 14: Collaborative mental health care for refugee children (Sri Lankan)
(Adapted from Rousseau, Measham & Nadeau, 2012).

This cultural consultation involved three meetings over a two-year period between the public health nurse (PHN), Mary, who visits schools and day care centres in the area where the CAMHS clinic is located, and a child psychiatric consultant. Mary is the main health professional providing care for Shiva, a young boy who arrived in New Zealand at the age of four with his mother Anna. Shiva was born into a happy, wealthy, well educated family in Sri Lanka. When Shiva was three, his father was kidnapped for political reasons and subsequently killed. Shiva and his mother were called to the hospital where, instead of finding Shiva’s father alive as they expected, they had to identify his tortured dead body. Anna, who was pregnant, was unable to protect Shiva from the horrific sight. Soon afterwards, Shiva and his mother were abducted and tortured, and Shiva witnessed his mother’s mistreatment.

Later, relatives smuggled them out of the country and they arrived in New Zealand where they applied for refugee status. On arriving in New Zealand, Anna had to be hospitalised because the torture had provoked a miscarriage. For an entire week, she lay between life and death in intensive care. Shiva sat quietly on a chair by her bedside (very surprisingly, he was not placed in a foster care setting). It is not clear whether Anna was discharged without a referral for further mental health care services or whether she did not attend follow-up appointments.

The family’s next contact with health and social services was established through Shiva’s day care. The day care workers were worried about Anna’s distrustful and avoidant behaviour. They reported that Shiva was extremely withdrawn, hid under tables and appeared to be terrified. They suspected physical abuse and severe neglect. Before reporting him to Child, Youth and Family (CYFs), they decided to consult Mary, the PHN who was their designated primary health care resource person. Mary’s work with Anna involved supporting her in organising a survival network in her neighbourhood. She taught her about food banks and helped her find furniture and appropriate clothing. Mary also helped Anna continue with her application for refugee status. In the process of helping Anna fill out her immigration papers, Mary found out about Shiva’s traumatic background by reading the written narrative that Anna had had to provide for her refugee application – Anna never spoke about this. Mary also became increasingly aware of the ongoing physical pain that Shiva and his mother continued to experience, and was concerned about its relationship with their past traumatic experiences.

Concerned about Anna and Shiva’s experiences, Mary encouraged the mother to consider
mental health and medical support for the family, but Anna refused this. At this point, Mary requested a first consultation during which she discussed the situation in the absence of Anna. Mary explained how she had been working to change the daycare workers’ perceptions of Shiva’s mother from a paranoid and potentially dangerous person to a severely hurt woman who, in spite of her fragility and emotional unavailability, was deeply attached to her son. During the consultation, a thorough review of all the services involved revealed that in spite of Anna’s reluctance to see a mental health professional, she had been seeing several doctors for both herself and for Shiva due to medical complaints and had been taking a number of psychotropic drugs, without significant results. Mary was unsure whether or not she should directly address the family’s traumatic story with Anna, stressing the mother’s massive avoidance behaviours and the fragility of their alliance. Moreover, she remained worried about Shiva’s anxious behaviour; although she felt that since her involvement with the family he was showing some signs of improvement. Mary also felt overwhelmed by the story that had been indirectly revealed to her when she helped Anna fill in the immigration papers. She turned to the consultant to obtain confirmation that her work on the alliance between the mother and the day care, trying to increase the level of empathy of the care providers, was effective. Mary felt a sense of emergency, which had led her to do a lot and to become exhausted. In spite of her intensive involvement, she felt helpless. The anger of the day care workers was framed as a misunderstanding. The consultation provided comfort and helped her shape more realistic expectations. Mary was supported in her continued efforts to help Anna set up a safe and supportive environment for the family, which included helping the mother to continue with her asylum status application. Art therapy was also offered for Shiva, and his mother agreed to this, although she shared that she did not have the energy to take him to the clinic. She did agree to this being provided at the day care by a CAMHS clinic trainee, which offered significant support both for the day care and for Shiva. The consultant also underlined the survival strengths of Shiva and Anna. This helped Mary to break out of the extremely stressful emergency mode of intervention which was burning her out, and helped her understand the feelings of helplessness engendered by her role as the only care provider who Anna would trust.

The second meeting with the consultant took place one year later. This time Anna, Shiva and Mary attended. Mary requested this second consultation to monitor Shiva’s progress and to address family dynamics, as Anna had re-established some connections with relatives in New Zealand. Anna refused the services of an interpreter, even when offered a choice in the interpreter’s gender and ethnic origin, so the consultation took place in English, a second language for all parties involved. Anna shared that Shiva’s fearfulness, including fear of hospitals, had diminished somewhat. In preschool, though still withdrawn, he was clearly a talented and caring little boy. For the first time, Anna was willing to discuss the possibility that her own physical symptoms and Shiva’s numerous somatic complaints could be linked to their traumatic experience. She also began to talk about karma as a means of understanding her past. Finally, with regard to family relations, she alluded to the burden
associated with her status as a widow. ‘Is it possible to escape the fate of widows?’ she asked. At the explanatory level, the Western model of trauma causality coexisted with traditional cultural models (karma and the role of the widow) to give meaning to the family’s suffering.

After the second consultation, Mary discussed her feelings of isolation. Anna was refusing to let other people (an interpreter or family members) help or support her. Very invested in the therapeutic relationship, Mary felt protective of Anna and while she did not feel she was angry, she felt overburdened and wanted help to re-establish social links for Anna. Anna finally gave Mary permission to contact their various doctors and to look for one family doctor who would be willing to coordinate all their medical needs. This consultation helped Mary to understand Anna’s ambivalence towards her relatives, opened the door to discussing both the protective (religious) and threatening (the role of widowhood) aspects of tradition and supported the co-ordination of services.

The third consultation took place 10 months later. Mary asked their new coordinating family doctor, Anna’s physiotherapist, Shiva’s art therapist and Anna to attend the meeting. Anna showed up briefly and informed all the professionals that she could not stay. The ensuing discussion revealed splitting processes among the family’s various caregivers. Anna’s anxiety about her son’s and her own medical problems was being transmitted to all with a sense of urgency, along with strong feelings of anger at the inadequacy of treatment and the unfairness of the system. Anna was simultaneously asking for help and portraying the health care providers as aggressors, thus reliving her memories of the hospital scene in Sri Lanka. For her, the health care system had become a theatre of traumatic re-enactment. The consultation helped to resolve the splitting by addressing these issues and changing the perception of the mother among the caregivers. During this third meeting the family’s caregivers argued among themselves about who was not doing enough, contesting the saviour role they each wished to claim, but also share. They projected their feelings of moral obligation onto others and channeled their anger and frustration into the collaborative relationship. The consultant pointed out this splitting, noting that the effect of trauma had influenced the family’s interpersonal relationships. Since Anna’s arrival, the splitting had been shifting from the day care to the extended family, and was finally being replayed among the caregivers themselves. The plan of action proposed a way to coordinate the physical and psychological care of Anna, who now agreed to enter psychotherapy, reframing the conflict as a symptom of the trauma. Mary remained the key player, with the child psychiatrist available to provide support.

Shiva remained very involved in his art therapy sessions. He endlessly built fortresses that were always attacked by monsters and armed men. He also portrayed hospitals as scary places. Gradually, he introduced scenarios that ended in less catastrophic ways, as protection became possible to envision. In the last session, he spoke directly about his
father for the first time. The therapist thought that the end of the sessions reminded him of his earlier loss, but also felt that he was offering her a gift, entrusting her with his most cherished memory before leaving.

Question 1: Describe the issues involved in the therapeutic alliance between the consultant (Child Psychiatrist) and the consultee (PHN); between the PHN and other primary carers; and between the PHN and the client.

Question 2: Explain the impact of vicarious trauma on the interactions between health professionals involved in this case and on their relationship with the client.

Refer to the Collaborative Mental Health Care for Refugee Children Section.

Discussion:

Alliance building and trauma transmission

Alliance building in cultural consultation is a multilayered task. It includes an alliance between the consultant and the person requesting the consultation, the consultee (the PHN), as well as an alliance among the various professional care providers involved and an alliance between them, the child and the family. These relations are often mediated by the consultee, who transmits to the consultant a coherent narrative constructed from fragments of stories and observations. The consultation request is organised around an image of the child and family that reveals a lot not only about the consultee - family relationship, but also about the relation between the consultee, surrounding institutions and their associated caregivers. When a family narrative is partially structured by war and organised violence, images of family members and of host country professionals tend to be polarised along a projective continuum. A traumatic story typically conjures up visions of a helpless victim, yet in the background there lies a troubling sense of unease, often expressed as a suspicion that the alleged traumatic experience is not authentic, or that the supposed victim is manipulative, or that the victim is neglectful or dangerous. The image of the benevolent self is protective for the primary care provider, and is sometimes also extended to other care providers and host-society institutions. Quite often, however, the illusion of individual and collective benevolence explodes when strains on the therapeutic relationship emerge.

In many ways the dynamics of an encounter with a refugee family mirrors larger societal processes framing the moral economy of our relation to the ‘other’ (Watters & Ingleby, 2004), confirming the benevolence of democratic, wealthy, immigrant-receiving countries and identifying refugees themselves as mainly responsible for the exclusion or rejection they may experience.

The consultant–consultee alliance can be beneficial in indirectly addressing such representations by proposing a complex appraisal of all the players involved and helping them to get beyond the splitting by acknowledging the complexities of individual and collective identities, including humanity’s universal capacity for being both helpers and
aggressors, and for individuals to have both benevolent and angry, vengeful and hateful feelings.

In order to resist splitting, the consultant needs to model the capacity to understand, reflect on and hold the negative projections and the experience of extreme harm that is being transmitted, and to acknowledge the gift that the client is offering the caregivers by conveying his/her experiences to them (Rousseau & Foxen, 2010). In parallel, the consultant assumes with the caregivers and host country institutions the fact that the host society may both perpetuate harm and alleviate it. This entails acknowledging the collective political responsibility of host country professionals for the historical events that have led to violence (for example, colonisation) and for the exclusion or marginalisation that minorities face in host countries as a result of structural and institutional discrimination.

As an ambivalent figure – a good-enough helper who at times may also be an aggressor – the consultant supports the consultee as he or she comes to terms with the loss of their idealised role as saviour and helps him or her to realise that sooner or later, they too will be perceived as aggressors. Recognising that this perception is not only a mere projection but also corresponds to the darker side of our collective and personal humanity is painful. In most cases, the consultee’s burden stems not so much from the many difficulties that must be overcome – difficulties in comprehension and in providing resources to people who are vulnerable and isolated and whose right to resources is often limited – but rather from the fact that the encounter forces caregivers to confront the aggressor in themselves. This is where the consultation holding takes place. The capacity to reconcile the two sides of themselves enables consultees to subsequently hold families through the recognition of their own anger and ambivalence.
The following are abbreviated terms used in this document:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADHB</td>
<td>Auckland DHB</td>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<tr>
<td>AODS</td>
<td>Alcohol and Other Drugs</td>
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<tr>
<td>Asian/MEA</td>
<td>Asian/ Middle Eastern and African</td>
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<tr>
<td>B-EDSRA</td>
<td>The Brief Emergency Department Suicide Risk Screening Assessment</td>
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<tr>
<td>BDI II</td>
<td>Beck Depression Inventory–II</td>
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<tr>
<td>BICS</td>
<td>Basic interpersonal communication skills</td>
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<tr>
<td>BYI-2</td>
<td>Beck Youth Inventory-2</td>
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<tr>
<td>CADS</td>
<td>Community Alcohol &amp; Drug Services</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<tr>
<td>CALP</td>
<td>Cognitive academic language proficiency</td>
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<tr>
<td>CAT</td>
<td>Community Assessment Team</td>
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<tr>
<td>CBT</td>
<td>Cognitive-Behaviour Therapy</td>
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<tr>
<td>CBT-E</td>
<td>Enhanced Cognitive-Behaviour Therapy</td>
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<tr>
<td>CD</td>
<td>Conduct Disorder</td>
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<tr>
<td>CDI</td>
<td>The Children’s Depression Inventory</td>
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<td>CES-D</td>
<td>Center for Epidemiological Studies Depression Scale</td>
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<tr>
<td>CFI</td>
<td>Cultural Formulation Interview</td>
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<tr>
<td>CM</td>
<td>Case Management</td>
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<tr>
<td>CMDHB</td>
<td>Counties-Manukau DHB</td>
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<tr>
<td>CBRS</td>
<td>Conners Comprehensive Behaviour Rating Scale</td>
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<tr>
<td>CYFS</td>
<td>Child Youth Family Service now Ministry for Vulnerable Children Oranga Tamariki</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>DSM-V</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition</td>
</tr>
<tr>
<td>eCHAT</td>
<td>Electronic Case-Finding and Help Assessment Tool</td>
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<tr>
<td>EDSRA</td>
<td>The Emergency Department Suicide Risk Assessment</td>
</tr>
<tr>
<td>EGM</td>
<td>Electronic Gaming Machines</td>
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<tr>
<td>EST</td>
<td>Empirically Supported Treatments</td>
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<tr>
<td>FBT</td>
<td>Family Based Therapy</td>
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<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>IAD</td>
<td>Internet Addiction Disorder</td>
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<tr>
<td>ICD-10</td>
<td>Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). World Health Organisation</td>
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<tr>
<td>IPT</td>
<td>Interpersonal Psychotherapy</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>IYP</td>
<td>Incredible Years Programme</td>
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<tr>
<td>M-CHAT</td>
<td>Modified Checklist for Autism in Toddlers</td>
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<tr>
<td>MEA</td>
<td>Middle Eastern and African</td>
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<tr>
<td>MELAA</td>
<td>Middle Eastern, Latin American, and African</td>
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<tr>
<td>MDD</td>
<td>Major depressive disorder</td>
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<tr>
<td>MI</td>
<td>Motivational Interviewing</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSE</td>
<td>Mental State Examination</td>
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<tr>
<td>MVCOT</td>
<td>Ministry for Vulnerable Children Oranga Tamariki (formerly Child Youth Family Services)</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>NRA</td>
<td>Northern Regional Alliance Ltd (previously NDSA)</td>
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<td>NZ</td>
<td>New Zealand</td>
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<tr>
<td>ODD</td>
<td>Oppositional Defiant Disorder</td>
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<tr>
<td>PAM</td>
<td>Potentially Avoidable Mortality</td>
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<tr>
<td>PCIT</td>
<td>Parent–child interaction therapy</td>
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<tr>
<td>PE</td>
<td>Psychotic experiences</td>
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<tr>
<td>PHO</td>
<td>Primary Health Organisation</td>
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<tr>
<td>PLE</td>
<td>Psychotic-like experiences</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SNZ</td>
<td>Statistics New Zealand</td>
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<tr>
<td>WCTO</td>
<td>Well Child Tamariki Ora</td>
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<tr>
<td>WDHB</td>
<td>Waitemata DHB</td>
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# Resources

## Resources for health providers

The following are cultural and language appropriate information and services available to CALD families.

<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Where to access</th>
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</table>
| Auckland Regional Public Health Service, Refugee Health Screening Service (ARPHS-RHSS) | • Auckland Regional Public Health Service, Refugee Health Screening Service  
• http://www.arphs.govt.nz/health-information/promoting-health-wellbeing/refugee-health/service  
• The RHSS Clinic provides screening and healthcare for all ‘quota’ refugees and asylum seekers at MRRC. Referral is made to appropriate services for ongoing medical needs including psychological services. Medical records can be requested with the permission of the client.  
• Contact: (09) 276-6719 |
| Refugees as Survivors NZ (RASNZ)  
RASNZ Auckland Regional Refugee Mobile Team | • The Auckland Regional Refugee Mobile Community Clinical Team is a multidisciplinary specialist unit comprising psychologists, psychiatrists, doctor, nurse, social worker and six refugee community link workers representing the Afghan, Burmese, Somali, Iraqi, Ethiopian, Sudanese, and Kurdish communities. The Mobile Team provides mental health services in assessment, intervention, counselling, social work, body therapies and a range of culturally responsive clinical therapies for trauma, family, and resettlement issues.  
• The Refugee Mobile Team collaborates with mainstream mental health services, to assist them in working more effectively with refugees. In some cases, the team will work together with mainstream providers, and in complex or high needs cases will manage cases and deliver treatment directly. [http://www.aucklandras.org.nz/#](http://www.aucklandras.org.nz/#)  
• Contact Refugees as Survivors New Zealand  
• Ph: (09) 270 0870  
• 0800 4 RASNZ (0800 4 72769)  
• Referrals to: [http://www.aucklandras.org.nz/m-contact.html](http://www.aucklandras.org.nz/m-contact.html) |
<table>
<thead>
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<tbody>
<tr>
<td><strong>screening tool with the follow-up interview (R/F)</strong></td>
<td>• <a href="http://mchatscreen.com/mchat-rf/translations/">http://mchatscreen.com/mchat-rf/translations/</a></td>
</tr>
<tr>
<td></td>
<td>• <a href="http://mchatscreen.c">http://mchatscreen.c</a></td>
</tr>
<tr>
<td><strong>Considering culture in autism screening:</strong> Training and facilitator guidelines</td>
<td>• <a href="http://www.maactearly.org/uploads/9/2/2/3/9223642/considering_culture_facilitatorguide_final_102116.pdf">http://www.maactearly.org/uploads/9/2/2/3/9223642/considering_culture_facilitatorguide_final_102116.pdf</a></td>
</tr>
<tr>
<td></td>
<td>• In Australia, the NSW Multicultural Health Communication Service acts as a clearing-house for all health and mental health-related multilingual resources. Resources may be accessed online <a href="http://www.mhcs.health.nsw.gov.au">http://www.mhcs.health.nsw.gov.au</a> Multilingual resources and publications are available. Translated resources are in 43 different languages. The website is updated monthly and resources are downloadable in pdf format.</td>
</tr>
<tr>
<td>** Suicide Prevention**</td>
<td><strong>Living is For Everyone (LIFE) &amp; MMHA</strong></td>
</tr>
<tr>
<td><strong>Helping someone at risk of suicide:</strong></td>
<td>Translated information available in the following languages: go to <a href="http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-MMHA">http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-MMHA</a></td>
</tr>
<tr>
<td></td>
<td>• Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese</td>
</tr>
<tr>
<td>** Mental Health Foundation of New Zealand**</td>
<td>• Asian mental health-translated information. Go to: <a href="https://www.mentalhealth.org.nz/get-help/resources/search/?topic=11&amp;topic_only=1">https://www.mentalhealth.org.nz/get-help/resources/search/?topic=11&amp;topic_only=1</a></td>
</tr>
<tr>
<td></td>
<td>• Physical assault or cyber bullying should be notified to the police. Every region has ethnic police liaison officers. For contacts see: <a href="http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers">http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers</a>.</td>
</tr>
<tr>
<td>** Caring for kids new**</td>
<td>• A guide for health professionals working with immigrant and refugee</td>
</tr>
<tr>
<td>Type of resource</td>
<td>Where to access</td>
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</tbody>
</table>
| to Canada        | children and youth.  
| Here to help BC Mental Health and Substance Use Service | • British Columbia Mental Health and Substance Use Service  
|                  | • [http://www.heretohelp.bc.ca/other-languages](http://www.heretohelp.bc.ca/other-languages).  
| Offord Centre for Child Studies – McMaster Children’s Hospital, Canada | • Information on: anxiety, autism, attention, behaviour, eating disorders, mood, substance abuse, Tourette’s.  
|                  | • [https://offordcentre.com/research/knowledge/](https://offordcentre.com/research/knowledge/).  
|                  | • Translated into: English, French, Arabic, Hindi, Italian, Portuguese, Punjabi, Simplified Chinese, Traditional Chinese. |
| Mental Health in Multicultural Australia (MHIMA) | • The Mental Health in Multicultural Australia (MHIMA) website offers translated mental health information. Go to: [http://www.mhima.org.au](http://www.mhima.org.au) |
| Victorian Transcultural Mental Health (VTMH) | • Provides information and translated resources. Go to: [www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-resources](http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-resources)  
|                  | • Website: [www.vtmh.org.au/](http://www.vtmh.org.au/) |
| Multicultural Mental Health Resource Centre (MMHRC)- Canada | • Provides mental health information for children, adolescents and parents  
<p>|                  | • Provides information about the following clinical instrument, available in a range of languages: General Perceived Self-Efficacy Scale (GSE) |
| Family Therapy Services for vulnerable children/young people 0-17 | • Stand Children Services offer family therapy services for the most vulnerable children/young people aged 0-17 years of age (including unborn) from maltreatment/exposure to chronic trauma and to support their recovery from that exposure and enhance their wellbeing <a href="http://standforchildren.org.nz/family-therapy-services">http://standforchildren.org.nz/family-therapy-services</a>. |
| List of Asian and Refugee services | • You will find a list of other Asian and Refugee services information here. <a href="http://www.ecald.com/Resources/Migrant-and-Refugee-Services">http://www.ecald.com/Resources/Migrant-and-Refugee-Services</a> |</p>
<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Where to access</th>
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<tbody>
<tr>
<td>Protection Unit/New Zealand Refugee Quota Programme.</td>
<td>Download Refugee Quota factsheets on major refugee groups currently being resettled in New Zealand including: Afghanistan, Colombia, Myanmar, Rohingya, Sri Lanka and Syria.</td>
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**Resources for consumers**

<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Description and where to access</th>
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</table>
| Parenting information including children with special needs | - The SKIP website is a tool to help parenting organisations and parents with positive parenting. Strategies with Kids - Information for Parents (SKIP) provides support, information and parenting strategies for parents and caregivers of children up to 5 years old.  
- The SKIP website [www.skip.org.nz](http://www.skip.org.nz) has resources in 19 languages including: Arabic, English, Te Reo Maori, Chinese (Simplified), Chinese (Traditional), Cook Island Maori, Farsi, Fijian, Hindi, Japanese, Korean, Nepali, Portuguese, Punjabi, Samoan, Spanish, Thai, Tongan, Vietnamese.  
- Topics include: Jealousy and fighting, Managing behaviour, Children with special needs, Ages and stages, Tantrums and temperament, Tips on stress etc. |
<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Description and where to access</th>
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</thead>
</table>
| Autism – Information for Parents translated (Massachusetts Act Early) | • Translated Parent Information Sheets, ASD Fact Sheets, and other helpful materials.  
| Autism – Information for Parents- Translated | • Translated Parent Information Sheets, ASD Fact Sheets, and other helpful materials.  
| Mental Health Foundation of New Zealand | • Asian mental health- translated information. Go to: [https://www.mentalhealth.org.nz/get-help/resources/search/?topic=11&topic_only=1](https://www.mentalhealth.org.nz/get-help/resources/search/?topic=11&topic_only=1) |
| Mental Health in Multicultural Australia (MMHA) | Translated information available in the following languages: go to [http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-MMHA](http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-MMHA) |

**What is an anxiety disorder?**
Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese

**What is a bipolar mood disorder?**
Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese

**Challenging behaviours**
Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese

**What is a depressive disorder?**
Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese

**What is an eating disorder?**
Amharic, Arabic, Assyrian, Simplified Chinese, Croatian, Dari, Dinka, English, Farsi, Greek, Italian, Khmer, Korean, Krio, Macedonian, Polish, Russian, Serbian, Spanish, Swahili, Traditional Chinese, Turkish, Vietnamese

**What is mental illness?**
<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Description and where to access</th>
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</thead>
<tbody>
<tr>
<td><strong>Korean Mental Health and Recovery resource</strong></td>
<td>Towards My Inner Han-gun-ghin: Mental Health and Recovery is a booklet written in Korean which provides useful information about mental health for Koreans living in New Zealand. It includes a brief introduction to major mental illnesses, a step-by-step guide on how to get help from a range of mental health organisations, different types of treatments and interventions available and useful contact details to get help. Downloadable from: <a href="https://www.mentalhealth.org.nz/assets/ResourceFinder/SWT-R.Booklet-2016-Final-Draft.pdf">https://www.mentalhealth.org.nz/assets/ResourceFinder/SWT-R.Booklet-2016-Final-Draft.pdf</a></td>
</tr>
<tr>
<td><strong>Mental Health in Multicultural Australia (MHIMA)</strong></td>
<td>The Mental Health in Multicultural Australia (MHIMA) website offers translated mental health information. Go to: <a href="http://www.mhima.org.au">http://www.mhima.org.au</a></td>
</tr>
</tbody>
</table>
| **Victorian Transcultural Mental Health (VTMH)** | • Provides information and translated resources. Go to: [www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-resources](http://www.mhima.org.au/resources-and-information/Translated-information/translated-mental-health-information-resources)  
• Website: [www.vtmh.org.au/](http://www.vtmh.org.au/) |
| **WHO Depression – Let’s Talk Campaign** | • Depression – Let’s Talk Campaign Information available in English; Arabic; Chinese; French; Russian; Spanish  
• [http://www.who.int/mental_health/evidence/March_2017_mhGAP_Newsletter.pdf?ua=1](http://www.who.int/mental_health/evidence/March_2017_mhGAP_Newsletter.pdf?ua=1) |
| **Korean/Chinese videos for parents of children with disabilities** | • Seven videos introduce parents to the New Zealand disability sector.  
• The videos have been recorded in English and produced in three versions with English, Korean and simplified Chinese subtitles. They follow an age-related, progressive format, so that parents can watch them individually or one after another. |
<table>
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<tr>
<th>Type of resource</th>
<th>Description and where to access</th>
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<tbody>
<tr>
<td>Disability Connect: Information for Parents of children with disabilities</td>
<td>They cover a variety of topics on health and disability, education and social supports which families may be eligible for. The videos include powerpoint slides with basic explanations and links to useful websites. The videos are available on YouTube and Vimeo. The YouTube version can be accessed through the Disability Connect website disabilityconnect.org.nz and on the Chinese website <a href="http://www.skykiwi.com">www.skykiwi.com</a>.</td>
</tr>
<tr>
<td>Disability Support Guide</td>
<td>This free support guide is designed to help parents and families of children and young people who have been recently diagnosed with a disability. The booklet aims to help families navigate their way throughout the disability sector, and sheds some light on the roles of the various ministries and organisations involved in the sector including Ministries of Health, Education, Social Development, Work &amp; Income, CYFs and Non-Government Organisations. Included is information on some supports which families may be eligible for. There is also information on disability policy and legislation in New Zealand. The disability sector can be complicated to understand so this overarching guidebook may be useful to families regardless of the age of their loved one. To order your free copy of the Disability Support Guide, please email Disability Connect on <a href="mailto:admin@disabilityconnect.org.nz">admin@disabilityconnect.org.nz</a>, or call us on 636 0351. The Disability Support guide is now available in English, and Simplified Chinese, Korean and Arabic. English: <a href="http://disabilityconnect.org.nz/resources/disability-support-guide/">http://disabilityconnect.org.nz/resources/disability-support-guide/</a> (Simplified Chinese, Korean, Arabic)</td>
</tr>
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</table>

### Children and youth migrant services

<table>
<thead>
<tr>
<th>Services</th>
<th>Service Provider</th>
<th>Location</th>
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<tbody>
<tr>
<td>Services for teenage gambling Asian Problem Gambling Public Health Services (Cantonese, Mandarin, Korean, Vietnamese, Thai and Japanese)</td>
<td>Asian Family Services</td>
<td>National</td>
</tr>
<tr>
<td>Services</td>
<td>Service Provider</td>
<td>Location</td>
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</table>
| **Refugees as Survivors NZ (RASNZ)**  
**RASNZ Auckland Regional Refugee Mobile Team** | The Auckland Regional Refugee Mobile Community Clinical Team is a multidisciplinary specialist unit comprising psychologists, psychiatrists, doctor, nurse, social worker and six refugee community link workers representing the Afghan, Burmese, Somali, Iraqi, Ethiopian, Sudanese, and Kurdish communities. The Mobile Team provides mental health services in assessment, intervention, counselling, social work, body therapies and a range of culturally responsive clinical therapies for trauma, family, and resettlement issues.  
The Refugee Mobile Team collaborates with mainstream mental health services, to assist them in working more effectively with refugees. In some cases, the team will work together with mainstream providers, and in complex or high needs cases will manage cases and deliver treatment directly.  
Contact Refugees as Survivors New Zealand  
Ph: (09) 270 0870  
0800 4 RASNZ (0800 4 72769)  
Referrals to:  
[http://www.aucklandras.org.nz/m-contact.html](http://www.aucklandras.org.nz/m-contact.html) | Auckland |
<p>| <strong>Shine (Safer Homes in NZ Everyday): support and Safe House accommodation for Victims of domestic violence</strong> | Shine offers a national toll-free Helpline (0508-744-633) that operates 7 days/week, from 9am to 11pm, which is staffed by trained professionals. Shine Safety First Advocates in Auckland Central and | National |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Service Provider</th>
<th>Location</th>
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<tbody>
<tr>
<td>North shore offer support and advocacy for women and children who have experienced abuse. Shine Safe House offers safe and supportive accommodation for women and children on Auckland’s North shore. KIDshine offers support specifically for children who have experienced domestic abuse.  <a href="http://www.2shine.org.nz">www.2shine.org.nz</a>.</td>
<td></td>
<td>Auckland</td>
</tr>
<tr>
<td>Umma Trust - Services for Muslim youth - Social work support for women and families (including youth from Muslim backgrounds)</td>
<td>Umma Trust - Social and Community Support for families from Muslim and Refugee backgrounds (see website: <a href="http://www.ummatrust.co.nz/services/">http://www.ummatrust.co.nz/services/</a>). UUMMA Trust provides CYFS accredited social work support for women and families, as well as support groups. To refer a person or family please contract UMMA Trust by email <a href="mailto:ummatrust@xtra.co.nz">ummatrust@xtra.co.nz</a> or telephone 09 815-0153. Address: 830 New North Road, Mt Albert, Auckland 1025. Hours: 9:30am - 4:30pm Monday – Friday.</td>
<td>Auckland</td>
</tr>
<tr>
<td>Disability Connect - Services for families with disabled children and young people Disability resource centre for families with children 0-21 years old. The service has cross cultural support workers and uses interpreters for non-English speaking parents.</td>
<td>Disability Connect offers families with children with disabilities information and advice about the services and supports available to children, young people and their families. The service has cross-cultural support workers and uses interpreters for non-English speaking parents.  <a href="http://disabilityconnect.org.nz/how-we-can-help/">http://disabilityconnect.org.nz/how-we-can-help/</a>. Contact details: Phone (09) 636 0351</td>
<td>Auckland</td>
</tr>
<tr>
<td>Services</td>
<td>Service Provider</td>
<td>Location</td>
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<tr>
<td>Auckland District Health Board: Asian clinical consultation service.</td>
<td>ADHB Asian mental health service Transcultural mental health service.</td>
<td>Auckland central</td>
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<tr>
<td>Asian cultural community health workers</td>
<td>For referral information go to; <a href="https://www.healthpoint.co.nz/public/mental-health-specialty/auckland-dhb-community-mental-health-services/">https://www.healthpoint.co.nz/public/mental-health-specialty/auckland-dhb-community-mental-health-services/</a></td>
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<tr>
<td>Transcultural mental health service</td>
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<tr>
<td>Asian cultural coordinators</td>
<td>WDHB Asian mental health service <strong>Referrals</strong></td>
<td>Waitemata region</td>
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<tr>
<td></td>
<td>Anyone can make a referral to use the WDHB AMHS e.g. self referral, GP, psychiatrist, counsellor, and other practitioners. For the referral form to: <a href="http://www.asianhealthservices.co.nz/Asian-Mental-Health-Service/Eligibility-Referrals/Referral-Form">http://www.asianhealthservices.co.nz/Asian-Mental-Health-Service/Eligibility-Referrals/Referral-Form</a></td>
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<tr>
<td></td>
<td>Contact details: <a href="http://www.asianhealthservices.co.nz/Asian-Mental-Health-Service/Contact-Our-Team">http://www.asianhealthservices.co.nz/Asian-Mental-Health-Service/Contact-Our-Team</a>.</td>
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<tr>
<td>Community Alcohol and Drugs Services (CADS) Asian Counselling Services</td>
<td>Regional Community Alcohol and Drug Services</td>
<td>Auckland</td>
</tr>
<tr>
<td>Counselling and support service for young people. Online youth support</td>
<td>Youthline Central</td>
<td>Auckland wide</td>
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<tr>
<td>and personal development programme</td>
<td>Youthline Waitakere</td>
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<td></td>
<td>Youthline North Shore</td>
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<td>Youthline Manukau</td>
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<tr>
<td>Services</td>
<td>Service Provider</td>
<td>Location</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>Youth health service Training and seminars</td>
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<tr>
<td><a href="http://www.youthline.co.nz">www.youthline.co.nz</a></td>
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<td><a href="mailto:talk@youthline.co.nz">talk@youthline.co.nz</a></td>
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<tr>
<td>Playgroups for mothers and their children 0-5 years old from refugee and migrant backgrounds. Locations: Central Auckland, West Auckland</td>
<td>Auckland Regional Migrant Services Charitable Trust (ARMS)</td>
<td>Auckland</td>
</tr>
<tr>
<td>Youth Mental Health Initiatives lead by MoH and MoE (go to <a href="http://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project/youth-mental-health-project-initiatives">http://www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project/youth-mental-health-project-initiatives</a>)</td>
<td>Ministry of Health – project lead 1. School Based Health Services Maintain and expand funding to School Based Health Services to decile 3 secondary schools. 2. HEEADSSS Wellness Check Expand the use of the HEEADSSS wellness checks in schools and primary care settings. HEEADSSS stands for Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Depression, Safety. 3. Primary Mental Health Expand funding to extend the current primary mental health service to all youth in the 12–19 year age group and their families. 4. E-Therapy Review and implement an internet-based e-therapy tool for young people to provide treatment that will focus on common anxiety and depression. This tool is called SPARX. 5. Primary Care Responsiveness to Youth Improve the responsiveness of primary care to youth including through drop-in services. Youth One Stop Shops (YOSS) – interim funding and secure funding</td>
<td>National</td>
</tr>
<tr>
<td>Services</td>
<td>Service Provider</td>
<td>Location</td>
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<tr>
<td>6. CAMHS &amp; AOD Follow up Review and improve follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and youth Alcohol and Other Drug (AOD) services.</td>
<td>CAMHS &amp; AOD</td>
<td></td>
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<tr>
<td>7. CAMHS and Youth AOD Access Improve access to CAMHS and youth AOD services through DHB wait time targets and integrated case management services.</td>
<td>CAMHS &amp; AOD</td>
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<tr>
<td>Support for LGBTQI communities Free counseling HIV tests HIV prevention HIV research They have Asian outreach programmes</td>
<td>NZ AIDS Foundation</td>
<td>National</td>
</tr>
<tr>
<td>Helping young queer and gender diverse people up to ages of 27 Information Advocacy Professional development Drop in Centre Peer support groups Consultation Training and youth development</td>
<td>Rainbow Youth</td>
<td>National</td>
</tr>
<tr>
<td>Preventing, Dealing and Complaining about Race-Related Bullying</td>
<td>All schools have policies regarding preventing and dealing with bullying. Ministry of Education has published information for schools on how to prevent bullying or dealing effectively with bullying if it occurs on their school. Website: <a href="http://www.education.govt.nz/school/student-support/student-wellbeing/health-and-wellbeing-programmes/bullying-prevention-and-response/">http://www.education.govt.nz/school/student-support/student-wellbeing/health-and-wellbeing-programmes/bullying-prevention-and-response/</a></td>
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<td>Location</td>
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<tr>
<td>When assault or cyber bullying is involved, it is a criminal matter, police should be notified. Every region in New Zealand has ethnic police liaison officers. Ethnic Liaison officers are advertised on the police website <a href="http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers">http://www.police.govt.nz/advice/personal-community/new-arrivals/ethnic-liaison-officers</a></td>
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Acknowledgements

The Waitemata DHB eCALD® Services acknowledge and greatly appreciate the following reviewers for their valuable contribution and time to review this resource and provide constructive feedback to assist us with finalising this resource development.

<table>
<thead>
<tr>
<th>Name</th>
<th>Section(s) Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Hiran Thabrew: Psychiatrist, Child Liaison Psychiatry, Starship</td>
<td>Full document</td>
</tr>
<tr>
<td>Hospital, ADHB</td>
<td></td>
</tr>
<tr>
<td>Dr Rajendran Pavagada: Psychiatrist, HBT North, CMDHB</td>
<td>Full document</td>
</tr>
<tr>
<td>Dr Arun Gangakhedhar: Paediatrician, WDHB</td>
<td>Full document</td>
</tr>
<tr>
<td>Dr Sharon Wong: Paediatrician, WDHB</td>
<td>Full document</td>
</tr>
<tr>
<td>Dr Margaret Mitchell-Lowe: Psychiatrist, Child Youth &amp; Family Mental</td>
<td>Full document</td>
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<tr>
<td>Health Services, WDHB</td>
<td></td>
</tr>
<tr>
<td>Associate Professor Elsie Ho, MNZM, PhD, Director – Centre for Asian</td>
<td>Full document</td>
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<tr>
<td>and Ethnic Minority Health Research, School of Population Health,</td>
<td></td>
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<tr>
<td>University of Auckland</td>
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<tr>
<td>Victoria Camplin-Welch: Clinical Psychologist (private practice)</td>
<td>Full document</td>
</tr>
<tr>
<td>Shizuka Torii: Clinical Psychotherapist (private practice)</td>
<td>Full document</td>
</tr>
<tr>
<td>Dr Shahin Payam: Clinical psychologist, Lecturer – School of Public</td>
<td>Full document</td>
</tr>
<tr>
<td>Health &amp; Psychosocial Studies; eCALD Course Facilitator</td>
<td></td>
</tr>
<tr>
<td>Mariska Mannes: eCALD Course Facilitator</td>
<td>Full document</td>
</tr>
</tbody>
</table>
References


Centre for Multicultural Youth (CMY) (2015). *Supporting the mental health of young people from refugee backgrounds: A submission to the Victorian Government’s 10 year mental health plan*. Carlton, VIC: CMY.


treatment-resistant PTSD and panic attacks: a cross-over design. *J. Trauma Stress*, 18(6), 617–629.


