Cultural diversity and early intervention

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People come from many different cultural backgrounds and their experiences of mental illnesses are varied. Both culture and illness are very complex and of even greater complexity are the interactions between cultural experience and mental illness. Studies have generally focused on psychotic illness, cultural syndromes or the nature of cultural interpretations of psychiatric disorders and their treatment, but many other issues are relevant for mental health in diverse cultural contexts.

Concepts of 'early intervention' are a Western construction, reflecting views of the development of illness, the virtues of being 'early' with regard to its identification and management, and an active 'interventionist' approach. Concepts of prevention are valued in Western contexts with constructions such as 'an ounce of prevention is worth a pound a cure'. However, in terms of national or international mental health policies, the commitment to both prevention and early intervention frames of reference is only a recent development in the mental health field (Second National Mental Health Plan, 1998).

Any attempt to develop and implement programs for the prevention of, or early intervention with, mental disorders experienced by people of diverse cultural backgrounds will need to be informed by both an understanding of relevant risk and protective factors influencing disorder evolution, and the culturally determined perceptions and experience of the illness. There is a need to know much more about these matters for it is clear from available Australian data that people of culturally and linguistically diverse backgrounds may be delayed in their presentation for care, their illness may be less recognised, and their knowledge of services may be less. Or there may be other barriers to access such as language, social attitudes and stigma.

Cultural factors and the experience of people from different backgrounds may contribute to vulnerability, or act as protective or mitigating influences. More is known of vulnerability factors than of protective factors. However, on the whole it is clear that the major disorders occur at fairly similar levels across different cultural settings, although their course and severity may vary.
Recognition of the extent of mental disorders and their health impact has been highlighted by the report on the Global Burden of Disease (Murray and Lopez, 1996). This revealed that in developing countries as well as in the developed countries, mental disorders make a major contribution to ‘disability adjusted life years’ (DALYS). Also are rising, and that unipolar depression alone will be the disorder with the second greatest health impact of all conditions by the year 2020. A similar study of health burden in Australia reports similar comparable findings and with mental health problems constituting a major proportion of the disease burden (Mathers, Vos & Stevenson, 1999). Thus, even across very disadvantaged and different cultural contexts there is an urgent need to address mental ill health and to lessen this very adverse health impact.

The population approach to mental health (Raphael, 2000) provides a conceptual framework that can identify and mobilise the range of effective interventions to address this impact at population and individual levels. The application of such an approach in a cultural context requires not only utilisation of the most effective treatment programs, but also the mobilisation of strategies for prevention and early intervention. It also calls for a whole-of-lifespan approach with primary, secondary and tertiary levels of services provision.

The necessary framework for prevention has been presented by Mrazek and Haggerty (1994) in the overview of ‘Reducing Risks for Mental Disorders’. They highlight the need to ensure that ‘no harm’ is done and to meet the needs of culturally diverse populations (p. 327). Cultural competence is necessary for the development and implementation of any such programs. The studies reviewed in Mrazek and Haggerty cover a number of minority and culturally diverse groups for whom effective, preventive and early intervention trials have taken place in the US setting. Nevertheless, the extension of such studies to real life prevention programs is still a critical step. Monitoring program integrity both within and across cultural settings requires a critical appraisal of the key elements that contribute to effectiveness (Hosman & Engels, 1999). These principles must then be both adapted to local community needs and extended in differing cultural frameworks so that when programs are implemented they can achieve relevant goals.

For any prevention or early intervention program there is a need to engage stakeholders to ensure a commitment to, and uptake of, the program. Thus, there will be a basic need for education about the value and nature of prevention in mental health: education that is attuned to the needs of different cultural groups as well as local communities. Researchers and service providers, both, will need to engage communities through equity in decision making, shared commitment, and agreed goals. The relevant explanations and understandings may need to be developed through ethnographic and qualitative research that can then inform the content, format and delivery of prevention and early interventions.

Key domains of science necessary for prevention (Mrazek & Haggerty, 1994, pp. 53–72) are neuroscience, genetics, epidemiology, and developmental psycho-
pathology. While neuroscience and genetics will be unlikely to vary significantly with culture, epidemiology and developmental psychopathology may. With respect to epidemiology there is a growing body of work of relevance (e.g. McDonald and Steele, 1997), but less in the relatively new and evolving field of developmental psychopathology (Rutter, 1997). This latter is of particular relevance, as the majority of effective prevention and early intervention programs are focused on family and developmental vulnerabilities and the interactions of environmental stressors with biological (including genetic) and social variables along the course of development. This should be an important area for future research in prevention, as the cultural determinants of development are potent environmental issues that may strengthen mental health, or indeed diminish it.

It is useful to review the current knowledge of, and opportunities for, prevention, to identify the cultural issues that are likely to be related, and to report on evidence or findings relevant for prevention.

**Perinatal Period and Early Infancy**

Not only is the perinatal and early infancy period a time of great relevance for the development of the foetus and infant, but it is also a time of great vulnerability. Ensuring optimal antenatal, obstetric and postnatal care involves protecting the developing baby from adverse environmental influences. These can include foetal alcohol effects, folate deficiency and neural tube defects, and birth complications with potential for cerebral damage, to name a few. Psychosocial development is also very relevant throughout this period. Both these sets of influences may be relevant to mental health and contribute to vulnerability during this period and later.

Prevention programs may also aim to decrease risks related to maternal mental health problems such as postnatal depression. Prevention, or early and effective treatment, can improve the mother’s capacity to meet the needs of the infant and to parent, as well as improving her own mental health. Other problems of a similar kind include anxiety disorders, and post-traumatic stress disorder related to traumatic birth experiences or a re-awakening of past trauma by the birth (Barnett, 1995; Boyce & Condon, 2000).

Different cultural views of pregnancy, birthing and infant rearing may set the context in which vulnerability to mental health problems may occur. Practices may also be protective. Factors that may be broadly influential include the value placed on women, expectations regarding the ‘ideal’ sex of the infant, family support, and the role of the partner or husband. Where there are strong cultural traditions of specific birthing practices additional stress and vulnerability may occur if these practices cannot take place.

A review of vulnerability among culturally diverse populations in a large Sydney region reported the following risk factors (South Western Sydney Area Health Service, 1996):
Lack of support to meet practical and emotional needs.
Conflict between traditional practices and those of Australian health services.
Life stresses including marital problems, conflict with extended family, unemployment and financial difficulties.
Past stresses such as previous trauma, being a refugee and those related to migration.
Issues related to the birth and parenting, including myths of motherhood, unplanned pregnancy, distressing birth experience, disruption to lifestyle, and gender of child.

Trauma, birthing and mental health have been reported on in a series of studies of Cambodian women (Fitzgerald et al., 1998). A major risk factor for postnatal depression in this cohort was pre-migration trauma experience and a significant number of women developed depression or anxiety symptoms. Other studies of Vietnamese and Arabic women have also shown significant levels of distress (Matthey & Barnett, 1997). The Edinburgh Postnatal Depression Questionnaire was translated into relevant community languages for these studies and these screening measures have been valuable for use in programs with different cultural groups. Prevention programs have not yet been well established in these cross-cultural settings, however.

Nevertheless, the evidence from other research has shown the effectiveness of early intervention for women with this type of vulnerability — e.g. increased scoring on this measure for general anxiety symptoms and/or depression (Barnett, 1995; Boyce & Condon, 2000) — and the potential to improve outcomes for infants (Field, 1992). There is also a strong case to promote secure and satisfying attachment for mother and infant.

Home visiting has been shown to improve outcomes for infants in high-risk settings, both decreasing risk of abuse, and assisting better long-term development and adaptations (Olds et al., 1997). While US studies have indicated the effectiveness of such programs for some minorities, they would require sensitive application of cultural requirements in their adaptations and testing. Nevertheless, this is a further opportunity for culturally specific prevention programs.

Preschool Years and Middle Childhood

Prevention in early and middle childhood has focused on enhancing parenting, particularly with children at risk of conduct and behavioural disorders (Sanders, 1995). Cultural prescriptions for child-rearing and family expectations will be important issues to address, but further research is needed to identify protective cultural patterns, as well as those that may be linked to vulnerability.

In the school years children from culturally and linguistically diverse backgrounds may be confronted by their differences, and by language problems if
English has not been the first language spoken at home. Prevention programs and early intervention need to recognise these factors but can be effective in school environments (Marshall and Watt, 1999) through programs to enhance parenting, through building optimistic thinking styles (Jaycox, Reivich, Gillham & Seligman, 1994; Seligman, 1997), building supportive school environments that promote connectedness (Hawkins & Catalano, 1992) and programs to lessen bullying (Olweus, 1991) and aggression (Grossman et al., 1997). Effective prevention and early intervention for anxiety and depression may also be implemented through school-based programs. (Spence, 1996)

Cultural contexts of family life, education, and values about child behaviour may influence the child's and family's adaptation and mental health and wellbeing. This is also a time when conflicts may occur in the relations between a child and the family because of pressures the child experiences from peers and the dominant Australian cultural norms.

Prevention and Early Intervention for Young People

This is often the period of onset of anxiety and depressive disorders, and increased vulnerability to these conditions and substance use disorder, as well as first onset of psychosis in the late adolescent or early adult years. Programs of early intervention and prevention such as 'Friends' and the Resourceful Adolescent Program (RAP) are of benefit and can usefully transpose to different cultural contexts, although in general cultural programs are still being tested (Spence, 1996; Barrett, 1999). These aim to strengthen social problem solving and competence and to enhance more positive cognitive styles.

It is also appropriate to continue to address prevention programs that lessen aggression, violence and antisocial behaviours, though outcomes are more difficult to achieve for these older age groups.

Of particular importance is suicide prevention. Young people of culturally diverse backgrounds may be at risk, but their vulnerability may not be recognised. Expectations from family in terms of achievement, education, and fulfilling family goals may be associated with enormous pressure and risk of failure. Depression, distress and poor self-esteem may indicate a particularly heightened risk but may be hidden by withdrawal or, alternatively, aggressive and acting-out behaviours.

Vulnerability to drug or alcohol problems may link to mental health problems such as depression, and again failing to meet family expectations may precipitate drug use. Drug and alcohol use, co-morbid depression or other mental health problems and life stresses will increase the risk of suicide in these groups of young people.

Adolescence is a period of independence and dependency, obligations and freedoms, and sexuality. All of these domains may be culturally determined in terms of approved or proscribed behaviours. Family obligations may be much more
powerful for some young people as compared to other young Australians. There may also be particular difficulties for young people with regard to sexuality, sexual preference, and expectations for young women and young men. All these factors may be influential for mental health in positive or negative ways.

Cultural identity, or ethnic identity, is also an issue of great relevance during these years, involving the dual identity of, say, Australian/Vietnamese and the simultaneous search for a personal identity. Other uncertainties such as discrimination, sense of belonging, peer relations, the nature of family attachments and powerful family demands may all impact on the young person’s mental health and wellbeing (Chen, 2000).

Adults’ Prevention and Early Intervention

Life transitions in the development of young adults such as pair bonding, the establishment of work and career, establishment of family, and birth of the first child are all major changes. They may, as for all cultures, increase vulnerabilities or provide a challenge that stimulates personal growth and maturation. Particular difficulties may arise also in work or the workplace if qualifications have not been transferable, or if language barriers exist, or if great demands increase vulnerability to workplace stress or injuries. While work may be acceptable for men, women’s work may be seen as in the home, increasing isolation; or work that can be accessed may be of very low status.

Prevention and early intervention may focus on such stressors or settings, and provide education, changed structures, recognition, and non-discriminatory, culturally appropriate prevention programs.

Older People

Older people from culturally diverse backgrounds may suffer stress in relation to loss, physical illness or disability or the onset of disorders such as dementia. Biological, psychological and social factors, including social disadvantage, may all contribute to an increased risk of depressive disorders, as may loss of function, and separation from family. The development of prevention and early intervention for mental health problems among older people can usefully focus on enhancing social networks, decreasing isolation, and enhancing support. Preventive programs can deal with issues around life stresses or transitions, particularly for those who are vulnerable through illness or disability. Depression screening measures such as the Geriatric Depression Scale are useful in assisting GPs and other health providers to detect depression early and effectively treat it in older people. It should be noted, too, that the presence of depression adds to the risk of poor recovery from heart attacks, cancer and stroke, so this is an important prevention focus in a holistic sense. Language access and networks of those with similar cultural experience and
language can be helpful as components of aged-care settings and processes. Organic factors such as dementia may also be associated with problems of memory and orientation to local cultures.

**The Health and Mental Health Systems**

As has been noted above health systems generally, and mental health systems in particular, may not always be attuned to the influence of culture in general, nor to specific cultures; nor to pathways to care; nor to perceptions of health, ill health and appropriate treatments, and likely outcomes. There is, thus, the potential to increase psychological distress and vulnerability in relation to identification of disorders and their treatment. Several actions can form the basis of a preventive approach in health systems, with respect to the mental health and wellbeing of culturally diverse populations.

1. Training for all staff to enhance cultural sensitivity and competence.
2. Requirements for questioning and information-seeking to establish cultural perceptions of the illness, the health system, potential treatments, and outcomes, can contribute positively. The provision of appropriate responses aims to diminish anxiety, establish rapport, explain the condition, tests and treatments, and to engage the person as necessary for prevention, early intervention, treatment and care.
3. Use of information in the client’s language wherever possible and the use of trained health care interpreters, explanatory pamphlets regarding the illness, the health system, prevention and treatment.
4. Identification of specific vulnerabilities, for instance, for persons previously exposed to medically-based torture; gynaecological procedures for those who have been raped; restriction of movement for those who have been imprisoned, and so forth. These matters call for not only sensitivity but a preventive approach so that the person is not re-traumatised. If earlier traumatic experiences are inadvertently awakened, early and effective interventions can be provided.
5. Recognition of holistic perceptions of health and mental health which appear in many other cultures; and recognition of spiritual and religious issues important to the person and perhaps relevant in the treatment being provided.
6. Recognition of other health and healing systems, including those culturally derived and those using traditional healers, and encompassing these as appropriate.
7. Ensuring, whenever possible, that there is either a bilingual worker or someone of similar cultural background as a support for persons in the health system, especially if there is no family.
8. Recognition of the greater centrality of the family in many diverse cultures; avoidance of unnecessary separations as imposed individualistic Western approaches.
There are potentially many other activities which could be drawn together to promote culturally appropriate health care, both physical and mental, and which contribute to a health care system which promotes mental health.

**Trauma, Loss and Prevention**

There is a great deal of evidence that the experiences of trauma and loss affect many people who become citizens after migrating as refugees, or following war, or as asylum seekers — experiences that may have profound and ongoing effects. It may not be possible to prevent these consequences, but promoting positive mental health and positive life adaptations will be vital. Silove and Steel (1998) have reported on the mental health and wellbeing of on-shore asylum seekers in Australia. Their valuable studies highlight the complex stressors faced by these groups, both before migration and after arrival (for instance, in detention, or as they seek to have their refugee status recognised).

Torture survivors are another group at very high risk of developing syndromes such as post-traumatic stress disorder and, again, opportunities for early intervention are few (McGorry, 1991). Nevertheless, prevention of further traumatisation will be one strategy and would involve organisational responses and social structures recognising potential for further traumatisation and ensuring as far as possible that it does not occur. Further experiences such as accidents, being exposed to violence, illnesses or encounters with authorities may reawaken earlier trauma and create opportunities for focused specialised counselling interventions when appropriate. The background of prolonged and chronic traumatisation is one where adaptations have been made (Silove, 1999). These should not be disrupted without clear indications that benefits are possible (Silove, Tarn, Bowles & Reid, 1991).

Secondary morbidity may also occur with post-traumatic stress disorder, including major depression, substance use disorders, and a range of social dysfunctions. A preventive approach can be of value in lessening the risk of these conditions. In addition, there may be opportunities to prevent transgenerational transmission of trauma effects (Danieli, 1998).

Resettlement can be very stressful, particularly if there have been massive losses, or if there are still family members in conflict zones (Jacques & Abbott, 1997). Opportunities for a preventive approach can be provided when the person involved is protected from potentially traumatic processes in resettlement, and where reunion is possible.

While much research with those of different cultural backgrounds and those who have settled in Australia has focused on traumatic stressors, these same groups have usually also experienced profound and multiple losses. The cultural prescriptions about death and dying, and loss and grief, may need to be recognised and encompassed in any response. Respect, ritual, recognition of appropriate death and funeral rites and practical support, as well as culturally appropriate counselling for
those at higher risk, can be of benefit. Again there is a shortage of appropriate research studies. Parkes, Laungari and Young (1997) have provided a conceptual framework to inform the understanding of loss and bereavement in different cultures, including the role of religion and belief, and the influence of secularisation. Campbell, Moore and Small (2000) emphasise the importance for health care, including palliative care, of developing an understanding and insight into cultural diversity and death and dying in the Australian context.

Past and multiple losses may be very difficult to grieve, yet opportunities may arise and a preventive approach may help the bereaved come to terms with what has happened. Loss of culture and identity, the guilt of having survived in the face of the multiple deaths of others, including genocide, may challenge adaptation, but again may be a focus for a preventive approach aiming to assist adaptation to what is intolerable. Cultural bereavement is a further valuable concept to assist understanding (Eisenbruch, 1992).

For both trauma and loss, subsequent experiences of these stressors in the place of resettlement may create new situations of adversity and vulnerability, as well as reawakening the earlier experiences. There are thus periods of increased vulnerability, but also, as it were, a double chance at prevention if this is not a situation which overwhelms the affected person’s defences. Counselling needs to be sensitive and the giving of testimony to past experience may be an important component of recovery. It should not challenge current adaptations unless there is a clear indication of the potential benefits, and clear indications of psychological safety for the person in so doing. Profound backgrounds of traumatisation make it more difficult and require considerable therapeutic skill. A cultural perspective on interventions such as cognitive behaviour therapy (Yeo, 1997) can be of value, as these concepts form the basis of much prevention and treatment relevant to the field of stress and adversity as precipitants of mental disorders.

**National Action Plan**

The National Action Plan for Mental Health Promotion and Prevention (Second National Mental Health Plan: 1998-2003, 1998) addresses prevention and promotion for people of diverse cultural and linguistic backgrounds (pp. 30–31). It identifies priority mental health targets for those populations as:

- promoting resilience and enhancing protective factors;
- reducing risk factors;
- increasing access to culturally relevant promotion and prevention initiatives;
- promoting mental health literacy and reducing stigma;
- promoting culturally sensitive responses and preventive intervention among care providers; and
- promoting community capacity building.
It is recognised that migration may be associated with risk factors that contribute to mental health problems, although there is also evidence that some migrants may have a decreased risk of disorder. Mihalopoulos and Pirkis (1998) report that factors associated with the migration process that may increase risk include:

- low socioeconomic status or a drop in status following migration;
- inability to speak the language of the host country;
- separation from family or loss of family;
- prejudice and discrimination in the host society;
- isolation from others of similar cultural background;
- traumatic experiences or prolonged stresses before or during migration (e.g. refugees, asylum seekers);
- being adolescent or elderly during time of migration; and
- extent of acculturation.

These factors and the settings in which they occur are important variables that influence the shape and nature of prevention and early intervention. Nevertheless, barriers to prevention exist for culturally diverse societies and these include failures to make programs culturally appropriate — for instance, available in community languages, and accessible. It is difficult to ‘sell’ prevention and early intervention in the broader community and its value may be even less clear to people with diverse perceptions of illness, health, health care and what may be appropriate interventions.

The National Action Plan (p. 30) indicates that good practice for culturally and linguistically diverse communities may include:

- providing information that will increase mental health literacy about prevention and early intervention in relevant community languages;
- engaging community leaders to promote mental health and to advocate for prevention;
- promoting culturally appropriate ways of destigmatising mental illnesses;
- providing community education on mental health and mental illness; and
- increasing cultural awareness and cultural competency in service responses and prevention initiatives.

The Action Plan goes on to recommend strategies to develop partnerships and improve the evidence base for promotion and prevention in culturally diverse communities. It also emphasises the need for development, implementation and evaluation of programs of known or potential effectiveness so they can be applied in diverse cultures and communities.

A number of initiatives attempt to address many of the above factors. For instance, campaigns to recognise and value cultural diversity have taken place, and programs in schools and communities have supported and celebrated cultural rituals and differences. Advocacy and community leaderships through Ethnic
Councils, multicultural and language broadcasting and television may all act to diminish some of the identified risks, although the actual benefits for mental health have not been established in specific studies.

Conclusions

Prevention, health promotion and early intervention are important for the mental health and wellbeing of Australians of culturally and linguistically diverse backgrounds. Cultural influences may increase resilience, contribute to positive mental health, or may increase vulnerability to mental disorders. Growing evidence of the effectiveness of prevention and early intervention, and their potential to impact on the burden of disease, means that people of diverse backgrounds should have equity in access to such programs. Current evidence suggests that they may access mental health care even later than their fellow Australians so that there may need to be affirmative action in program development and implementation, targeted to cultural needs. Above all, however, there is a need for much further research in this field, research for culture and mental health, to provide the basis for effective and accessible, culturally appropriate programs which improve the mental health and wellbeing of these populations.

References


bridge that can carry you over. In B. Ferguson & D. Barnes (Eds) Perspectives on transcultural mental health. Sydney: Transcultural Mental Health Centre.


1990 and projected to 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization. (Global burden of disease and injury series: v. 1).


South Western Sydney Area Health Service (1996) Highlighting diversity: NSW review of services for NESB women with postnatal distress and depression. Liverpool, NSW: South Western Sydney Area Health Service.
