Need to Culturally Adapt and Improve Access to Evidence-Based Psychosocial Interventions for Canadian South-Asians: A Call to Action

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ABSTRACT

Research into social determinants of mental and emotional health problems highlighted the need to understand the cultural factors. Mental health of immigrants is influenced by a variety of cultural, psychological, social, and economic factors. There is some evidence to suggest that South Asian people have higher rates of mental and emotional health problems than the rest of the Canadian population. Limited research also suggests that psycho-social factors are highly likely to be responsible for these high rates of mental health problems. These psychosocial factors may be impeding access and engagement with the services. These socially determined emotional and mental health problems are more likely to respond to psychosocial interventions than biological treatments. Evidence-based psychosocial interventions such as Cognitive Behaviour Therapy (CBT) and Acceptance and Commitment Therapy (ACT) might offer the way

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forward. CBT can be offered in a low-cost, low intensity format in a variety of settings, thus addressing the attached stigma. However, these interventions need to be culturally adapted, as these are underpinned by a Western value system. CBT has been culturally adapted and found to be effective in this group elsewhere. This opinion paper describes the need to enhance research on psychosocial determinants of the mental and emotional health problems, status, and the psychosocial determinants of health amongst South Asians in Canada to inform our understanding of the cultural specificity of psychosocial interventions.

Keywords: South Asian, mental health, Canada, psychosocial interventions, cognitive therapy

RÉSUMÉ

La recherche portant sur les déterminants sociaux des problèmes de santé mentale et émotionnelle a mis en évidence la nécessité de bien comprendre les facteurs culturels. La santé mentale des immigrants est influencée par divers facteurs d'ordre culturel, psychologique, social et économique. Certaines données suggèrent que les personnes d'origine sud-asiatique affichent des taux plus élevés de problèmes de santé mentale et émotionnelle que le reste de la population canadienne. Un nombre limité de recherches suggèrent également que des facteurs psychosociaux seraient fort probablement responsables de ces taux élevés de problèmes de santé mentale. Ces facteurs psychosociaux pourraient entraver l'accès et l'engagement dans les services. Il semble plus probable que ces problèmes de santé émotionnelle et mentale déterminés par la société répondent davantage à des interventions psychosociales qu›à des traitements biologiques. Des interventions psychosociales fondées sur des données factuelles telles que la thérapie cognitivo-comporte-mentale (TCC) et la thérapie d'acceptation et d'engagement (TAE) pourraient être la voie à suivre. La TCC peut être proposée sous une forme peu coûteuse et à faible intensité dans divers contextes, ce qui permet de lutter contre la stigmatisation associée aux problèmes de santé mentale et émotionnelle. Toutefois, ces interventions doivent être culturellement adaptées du fait qu'elles prennent appui sur un système de valeurs occidentales. Culturellement modulable, la TCC s'est avérée efficace pour traiter la population asiatique à d'autres endroits. Le présent document d'opinion décrit la nécessité d'intensifier la recherche sur les déterminants psychosociaux des problèmes de santé mentale et émotionnelle, le statut et les déterminants psychosociaux de la santé chez les personnes d'origine sud-asiatique vivant au Canada, et ce, afin d'amé-liorer notre compréhension de la spécificité culturelle des interventions psychosociales.

Mots clés : sud-asiatique, santé mentale, Canada, interventions psychosociales, thérapie cognitive

Although neurobiological and genetic contributors to mental disorders are well-established areas of research, there has been less work done on social and cultural determinants of mental illness, despite increasing recognition of their importance and relevance in diverse societies like Canada (Dunn & Dyck, 2000; Kirmayer & Gold, 2011). In the most recent census, approximately 22% of Canadians identified themselves as a member of a "visible minority," and people of South Asian origin are the largest of these ethnocultural minorities (Statistics Canada, 2016). This paper emphasizes the need for research on the mental health status and psychosocial determinants of health of South Asians in Canada to inform our understanding of the cultural specificity of psychosocial interventions. Efforts to adopt evidence-based practices in mental health must go along with an increase in research on ethnocultural minority populations to ensure that services and interventions are appropriate for Canada's diverse population (Whitley, Rousseau, Carpenter-Song, & Kirmayer, 2011). Work on the cultural specificity of the experience and expression of mental disorders and

culturally shaped modes of coping, healing, and recovery can guide the cultural adaptation of psychosocial interventions to enhance access, acceptability, and treatment outcomes.

MENTAL HEALTH OF CANADIAN IMMIGRANTS

There are well-established links between mental health and psychosocial factors including socio-economic status, social support, education, physical health, employment, and integration in the local ethnic community and wider society (Dunn & Dyck, 2000). Migration and acculturation stress, as well as particular social barriers and inequities commonly experienced by many ethnic minority groups, have been found to contribute to significant distress in these populations (Beiser, 2005). Other social determinants of the mental health of ethnic minorities in Canada identified by studies include discrimination, social exclusion, and economic hardship (Keleher & Armstrong, 2005). Ethnic differences are evident in referral patterns to the emergency psychiatric services and in inpatient psychiatric admissions (Chiu, Lebenbaum, Newman, Zaheer, & Kurdyak, 2016; Rotenberg, Tuck, & McKenzie, 2017; Rotenberg, Tuck, Ptashny, & McKenzie, 2017).

While refugees face elevated rates of mental disorders related to trauma, research in Canada has provided evidence for an initial "healthy immigrant effect," in which newcomers to Canada have a better health profile than their Canadian-born counterparts within the first 10 years of immigration. However, the mental health of immigrants declines to levels below their Canadian peers after that time span (Kennedy, Kidd, McDonald, & Biddle, 2015). This decrease in mental health over the post-immigration period has been attributed by researchers in part to the effects of discrimination and socio-economic inequality (Ekanayake, Ahmad, & McKenzie, 2012).

Recently arrived immigrants face challenges related to changes in social roles, acculturative stress, and exposure to racial discrimination. Immigrants also face psychosocial stress related to the acquisition of a new language, sense of isolation, economic burden, and feeling homesick (Noh & Avison, 1996). Newcomers face disadvantages in the job market and are frequently under-employed because their training and credentials may not be recognized (Dean & Wilson, 2009; Reitz, Curtis, & Elrick, 2014). However, despite making use of general healthcare at rates comparable to the general population, newcomers are significantly less likely to use mental health services, even when their level of psychological distress is taken into account (Kirmayer et al., 2007). This underutilization of mental health resources needs further research to understand the specific needs, concerns, and vulnerabilities of cultural communities and their methods of understanding mental health problems (Na, Ryder, & Kirmayer, 2016).

There have been attempts to apply frameworks of resilience to conceptualize positive psychosocial adaptation in post-migration populations (Simich & Andermann, 2014). These studies highlight culturally grounded modes of coping, adaptation and recovery (Adeponle, Whitley, & Kirmayer, 2012; Na et al., 2016; Virdee et al., 2017). While the goals of symptom reduction, improved functioning in social roles, and the pursuit of life projects may be similar for diverse populations, the way in which these goals are realized may differ according to the intersections of age, gender, developmental stage, and many other aspects of identity that depend on cultural values and social context (Kirmayer, Mezzich, & Van Staden, 2016). The recovery model, while promoting a much needed shift toward person-centred outcomes, is often framed in terms that emphasize individualistic values of autonomy, independence, and achievement as well as materialism, and

needs rethinking to engage with the collectivist values of family, community, and spirituality that are central to the way many South Asian immigrants and others conceptualize health and well-being (Adeponle et al., 2012; Na et al., 2016; Virdee et al., 2017; Whitley, 2016).

Social support has been shown to be a positive factor in immigrant adjustment and resilience because it helps immigrants deal with multiple social stressors (Ahmad, Rai, Petrovic, Erickson, & Stewart, 2013; Karasz et al., 2019). Research also shows that social support by service providers can be effective in reducing psychological distress when health providers have adequate understanding of the social situations experienced by immigrants (Noh & Avison, 1996). While ethnic minority individuals may benefit from supportive interactions within the networks of their own communities and families, which can provide culturally appropriate responses to their difficulties, the cultural safety and competence of mental health services can also be important contributors to well-being and social integration (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Huey Jr., Tilley, Jones, & Smith, 2014; Kirmayer, 2012; Kirmayer et al., 2011; Renzaho, Romios, & Sonderlund, 2013).

MENTAL HEALTH OF SOUTH ASIAN CANADIANS

South Asian Canadians are a growing population with diverse ethnic, religious, and geographic origins who have come to Canada in successive waves since the late 1800s. From 1996 to 2001, the South Asian origin population in Canada rose by 33%, while the rest of the Canadian population grew only by 4% (Government of Canada, 2011). At 1.9 million, the South Asian population (including those migrating from India, Pakistan, Afghanistan, Bangladesh, Nepal, Bhutan, Maldives, Africa, Sri Lanka, and other countries) are the largest visible minority group in Canada (Statistics Canada, 2016). This population continues to grow rapidly, and it is estimated that by 2031, just over half (55%) of immigrants could be born in Asia, with South Asians expected to represent 28% of those belonging to a visible minority in Canada (Statistics Canada, 2011). According to the 2016 Canadian census, India ranked as the second source of country of immigration to Canada, representing 15.6% of recent immigrants, and Pakistan is currently among the top 10 source countries (Statistics Canada, 2016). Improving the mental health care of South Asians is thus an important emerging need for Canada (McKenzie, Agic, Tuck, & Antwi, 2016). However, there is a paucity of research on the mental health experiences and needs of this diverse community (Khan, Kobayashi, Vang, & Lee, 2017). In particular, research on South Asian Canadians' mental health challenges, access to care, psychosocial stressors, idioms of distress, and relevant evidence-based interventions is still in its infancy.

There are limited data on the rates of common mental disorders, including anxiety and depression among South Asian immigrants to Canada. In the United Kingdom, the rates of depression among South Asian immigrants have been reported to be higher than those of the host population (Husain, Creed, & Tomenson, 1997). The limited research on the mental health of South Asian origin Canadians shows that older adult South Asian immigrant populations in Calgary had a rate of mild depression (21%), more than twice the national average (10%; Lai & Surood, 2008). In another study, based on self-reported data from Statistics Canada, Canadian-born South Asians who were unemployed and physically inactive, reported increased rates of a diagnosed mood or anxiety disorder compared with the first-generation South Asians (Islam, Khanlou, & Tamim, 2014). Moreover, first-generation migrants who arrived at the age of 17 or younger were found to be at significantly higher risk of mood and anxiety disorders, compared to those arriving at age 18 and

older (Islam, Khanlou, & Tamim, 2014). Similarly, a recent study carried out in Toronto found that among South Asian women from Sri Lanka, Pakistan, and India depression was associated with cultural and socio-economic factors (Ekanayake et al., 2012).

The social determinants of mental health for South Asian immigrants may be obscured by common stereotypes (Frey & Roysircar, 2006). A culturally competent approach would consider the relevance of systemic factors and variations in South Asian family structure (Guzder, 2014). Acculturation and assimilation further complicate generational variations in gender roles amongst South Asians who are embedded in systems with the resonances of centuries of tradition. This systemic understanding can support the development of culturally informed interventions to reduce distress, promote equity and wellness related to these complex post immigration situations (Agarwal-Narale, 2005). Cultural competence and cultural formulation to identify specific issues and treatment approaches would be enriched by further research with these communities to better understand the complexity of their mental health needs and concerns. Mental health problems that are strongly shaped by social and cultural factors may be more likely to respond to psychosocial interventions.

Inequities in Healthcare Access for South Asians

A study based on the Canadian Community Health Survey, found that compared to other ethnocultural groups, South Asians with a major depressive episode reported the highest proportion (48%) of unmet mental healthcare need and highest percentage (33%) of perception of barriers to the availability of mental health care (Gadalla, 2012). Barriers to supports and services included stigma around mental health and addiction issues and lack of access to linguistically and culturally appropriate care.

The lack of interpreter services for South Asian languages creates additional barriers to accessing health services and communicating with healthcare professionals (Halwani, 2004). However, the problem of mutual understanding goes well beyond language (Brisset et al., 2014; Kirmayer, 2015). As a participant in a focus study of ethnic minorities' access to healthcare put it: "Language and culture play a major role in mental health service delivery. For example, if I go to a service provider who doesn't know my language and is not familiar with my culture, first of all, I will not be able to explain my problem to him/her as I want to say it, secondly, even if he/she gets me, [he/she] will still not be able to provide me with culturally appropriate treatment which is very important" (Hansson, Tuck, Lurie, & McKenzie, 2010). Cultural and linguistic factors not only influence the detection and reporting of mental health problems and impede access to mental health services, they are of fundamental importance to providing health equity and optimal care especially in the mental healthcare delivery where in-depth communication is essential both for assessment and intervention (Fung & Wong, 2007).

The Case for Culturally Safe and Competent Psychosocial Interventions

The Mental Health Strategy for Canada proposes that the health system should respond to the diverse needs of all people and that people have equitable and timely access to appropriate, effective, and evidence-based treatments and supports that attend to the unique sociocultural needs of that particular group (Bartram et al., 2012). To achieve this, the Strategy adopts the frameworks of cultural safety and cultural competence. Cultural safety attends to historical, social, structural, and political economic factors that create inequities

in power and make interactions between minorities and societal institutions like the healthcare system unsafe (Anderson et al., 2003). Redressing these inequities requires changes at many levels, including health systems, institutional practices, clinical interaction, and therapeutic interventions (Kirmayer, 2012). Here, we are particularly concerned with the ways in which mental health interventions are framed and delivered. The Mental Health Commission of Canada's Case for Diversity reports further details and an agenda for improving mental health services for ethno-cultural and racialized populations (McKenzie et al., 2016).

Available research suggests a strong link between depression and anxiety and social and cultural factors among South Asians (Islam et al., 2014). Development of evidence-based psychosocial interventions, therefore, should be a priority for clinical services. There is now sufficient evidence that culturally adapted interventions can be effective (Rathod et al., 2018). A recent meta-analysis of culturally adapted interventions for mental health problems reported an overall effect size of 0.67 and found CBT was the most commonly adapted intervention (Hall, Ibaraki, Huang, Marti, & Stice, 2016). Other less commonly used interventions included education, problem solving, interpersonal therapy, and family therapy. Evidence-based psychosocial interventions such as CBT, family therapy, interpersonal therapy, and Third Wave Therapies consistent with Asian cultures, such as ACT (Fung, 2015a; Fung & Wong, 2017; Fung & Zhu, 2018), should be made more widely accessible (Na et al., 2016). These interventions can be integrated into existing clinical services, provided in lower-intensity formats in non-medical community settings, or adapted as self-help programs. Culturally adapting psychotherapy, like CBT and ACT, for individual clients can not only make it more accessible and acceptable to clients but may increase its therapeutic effectiveness (Fung & Lo, 2017; Lo & Fung, 2003).

Current psychotherapies developed in North America and European contexts and therapist training are largely informed by Western individualistic values (Kirmayer, 2007). To enhance acceptability, adherence, and effectiveness, evidence-based psychosocial interventions can be culturally adapted for specific populations (Naeem et al., 2015; Naeem, Phiri, Rathod, & Ayub, 2019). There is emerging evidence that culturally adapted evidence-based therapies can better meet the needs of South Asians (Naeem, Phiri, et al., 2015). Adapted interventions have been found to be effective for South Asian immigrants in the United Kingdom (UK) and in South Asia (Husain et al., 1997; Husain et al., 2013, 2014; Naeem et al., 2014; Naeem, Saeed, et al., 2015, 2015; Rathod et al., 2013; Rathod, Kingdon, Phiri, & Gobbi, 2010). These initiatives and research in the UK are highly relevant to the needs of South Asians in the Canadian context and should be extended to address the needs of Canada's diverse South Asian communities.

Ethnocentric bias in our mental health research, training, and service systems remains a problem (Kirmayer, 2014). The lack of research on culturally adapted evidence-based therapies for minority populations undermines goals of health equity by depriving a growing segment of the population of cost-effective, evidence-based treatments. The lack of attention to cultural diversity in mental health care reinforces barriers to access care and fails to reduce stigma (Whitley et al., 2011). Providing evidence-based treatments that are culturally adapted can improve access, increase effectiveness and reduce stigma.

A recent example of work on cultural adaptation is the Strength in Unity study, a multi-centre study that examined the effectiveness of ACT (Fung & Wong, 2014), Contact-based Empowerment Education (Bender & Guruge, 2014), and psychoeducation (Fung, 2015b) for Asian men in Toronto, Calgary, and Vancouver (Fung et al., 2017; Sato, Este, & McLuckie, 2016; Hoong, Jiang, Patel, Morrow, 2016). The study, based

on previous success in using similar interventions to reduce HIV-related stigma in ethnoracial groups and produce champions of change (Li et al., 2017), examined the stigma of mental illness among Asian men and utilized culturally appropriate interventions to decrease stigma and mobilize Asian men, both with and without mental illness, to engage in championship activities. In Toronto alone, more than 500 men were recruited in this process, and the interventions were found to reduce stigmatizing attitudes and internalized stigma, with trained champions logging over 2,500 activities in championing mental health (Fung et al., 2017).

CONCLUSIONS

The limited research evidence available indicates that South Asian origin immigrants have relatively higher rates of depression and anxiety than the general Canadian population. Little is known about trends across the lifespan for this population but children and youth, young mothers, and geriatric populations have been recognized as having specific mental health issues. Despite these increased rates, South Asians may make less use of mental health services. Low rates of mental health service utilization may not indicate lack of need: depression and anxiety may be both prevalent and undertreated in the South Asian population. Despite resilience and high functioning—which have reinforced the myth of the South Asians as a model minority—research suggests that psychosocial factors may be impeding mental health access. Research also underscores the importance of social and cultural factors that need to be considered in assessment and treatment planning. These socially determined emotional and mental health problems may be more likely to respond to psychosocial interventions than to biological treatments. There is a pressing need for research on social determinants of mental health and the development and evaluation of innovative, evidence-based psychosocial interventions that are culturally adapted for this population. In addition to improving access and treatment effectiveness, culturally safe and competent approaches to mental health services can contribute to the reduction of stigma and promotion of social integration and recovery.

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