

The Development and Therapeutic Modalities of a Transcultural Child Psychiatry Service

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ABSTRACT

Introduction: To look at the specificities of the work of a Transcultural Child Psychiatry Team developed to meet the need for specialized services for Montreal and Quebec's culturally diverse immigrant and refugee pediatric population. **Method:** A Transcultural Child Psychiatry Team was started at McGill University in 1995. The clinic's development and method of service provision for its patient population will be described. **Results:** Modalities of assessment and treatment are modified to meet the needs of the team's clientele and also reflect the philosophical underpinnings of the team's practitioners. **Conclusion:** In this model of service delivery, current mental health care practice is modified in order to address the social specificities and cultural diversity of transcultural child psychiatric populations.

Key words: transcultural psychiatry, immigrant, refugee, children, mental health, service delivery

RÉSUMÉ

Introduction: Étudier les spécificités d'un Service de pédopsychiatrie transculturelle conçu pour répondre aux besoins de la population multiculturelle de Montréal et du Québec en matière de services spécialisés. **Méthode:** Un service de pédopsychiatrie transculturelle été créé à l'Université McGill en 1997. L'article décrit la création de la clinique et la méthode de prestation des services. **Résultats:** Les modalités d'évaluation et de traitement sont adaptées aux besoins de la clientèle, et reflètent la philosophie des intervenants de la clinique. **Conclusion:** Dans ce modèle de prestation de services, la pratique courante en santé mentale est modifiée pour tenir compte de la diversité socioculturelle de la clientèle qui a recours aux services psychiatriques.

Mots clés: transcultural psychiatry, immigrant, réfugié, enfant, santé mentale, services

INTRODUCTION

Newly arrived children make up a significant subgroup of youth in Canada. In Montreal, Quebec, first and second generation immigrant and refugee children make up approximately 50% of the school-age population. A recent review (Lustig et al., 2004) outlines the stressors faced by children and adolescents who have experienced organized violence, highlighting their strengths as well as their vulnerabilities, and identifying protective factors for the mental health of refugee youth. A recent epidemiological survey of newcomer immigrants from four ethnocultural groups in Montreal found that 47% had witnessed some form of organized violence and 28% had personally suffered persecution (Rousseau and Drapeau, 2002). This implies that, at least in Montreal, some immigrant newcomers will also have been exposed to stressors associated with organized violence.

There has been a concern that children who come from minority ethnocultural groups utilize conventional mental health services less than majority ethnocultural group youth, are referred by different sources, and when referred, are less likely to continue in follow-up after the first appointment (Pepler and Lessa, 1993; Roberts and Cawthorpe, 1995). There has also been an increasing recognition that conventional child psychiatry in North America is largely based on western and bio-medical expertise. Little non-western and non-medical knowledge has been incorporated into our current models of identifying, understanding and treating childhood emotional, behavioural and social difficulties.

This is also the case for models addressing the effects of organized violence in children (Rousseau and Measham, in press). Our current diagnostic and treatment models are more heavily

centered on identifying pathology with less support of areas of strength and resilience, their scope focuses more on individual factors with less inclusion of social and cultural factors, and they place more emphasis on the experience of traumatic and stressful events that occur in the pre-migratory context, with less emphasis on post-migration stressors, including the ways in which newcomers are welcomed into host societies.

In view of the relatively large numbers of refugee and immigrant children in Montreal, and in light of the need to further develop models of service provision, a decision was made to set up a consultation and treatment team for immigrant and refugee children at McGill University. Training, research, and clinical care were identified as priorities to be combined in one program in order to generate new knowledge and at the same time attempt to transfer models of care to primary care settings. This paper will describe the Transcultural Child Psychiatry Team's development, method of functioning, and clientele, including child patients as well as others interacting with the service, such as family members, members of a child and family's support network, and referring professionals. Both clinical and philosophical aspects of the team's methods of providing care will be detailed with case vignettes. The paper will conclude with an elaboration of new directions in service provision which have been learned from this experience.

THE DEVELOPMENT OF THE TRANSCULTURAL CHILD PSYCHIATRY TEAM

The Transcultural Child Psychiatry Team of McGill University is influenced by the dual institutional foundations of McGill's Division of Social and Transcultural Psychiatry, first set up as a joint venture between the Departments of Psychiatry

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and Anthropology at McGill in 1955, and by its hospital base, the Montreal Children's Hospital, which has had a long tradition of serving Montreal's culturally diverse community, offering a multiculturalism program addressing issues of culture in service delivery since 1986 (Clarke, 1993). The team also collaborates closely with McGill University's Cultural Consultation Service, located at the Institute of Community and Family Psychiatry at the Sir Mortimer B. Davis Jewish General Hospital, which was formed in 1999 under the leadership of Dr. Laurence Kirmayer, Director of McGill's Division of Social and Transcultural Psychiatry.

The Transcultural Child Psychiatry Team at the Montreal Children's Hospital was formed in 1995 under the leadership of Dr. Cécile Rousseau, a clinical and research psychiatrist whose long involvement and contacts with community organizations working with refugees situated the team within a broad grassroots network and partnership (Foxen P, 2001).

Treatment provided by the Transcultural Child Psychiatry Team aims at representing multiple ethnocultural backgrounds as well as multiple professional disciplines, and presently includes psychiatry, psychology, and the creative arts therapies including drama, art and sand play therapy. Children and youth who had experienced war or migration trauma were considered a priority for access to services when the team was established. Children who had experienced family separation and reunification as a result of the migration process, families who had experienced organized violence, unaccompanied refugee minors and newly arrived children who were adjusting to a new schooling and social context were also considered particularly appropriate for referral. In addition, the team welcomed referrals from families or service providers where the elaboration of cultural issues was identified to be an important aspect of diagnosis or treatment provision. Children of any age from anywhere in the province of Quebec were able to be referred or to self-refer to the team.

Local, national and international colleagues and collaborators from multiple disciplines contribute to our elaboration of methods of treatment of psychological difficulties in immigrant and refugee children. A part of this work has been a reflection of how newcomers are welcomed into host societies that have both their own internal divisions as well as historical or current international conflicts. The service is equally part of a greater Montreal network of individuals and groups who are interested in expanding current models of health to incorporate community approaches.

THE ASSESSMENT PROCESS

The initial assessment consists of a multidisciplinary team evaluation, which involves an evaluation of the presenting problem with a professional interpreter and cultural broker and the team's culturally diverse multidisciplinary team, representing multiple professional backgrounds and identities (Rousseau, 1998). The referring party, the patient and his or her family and other persons considered important in their support network are invited to the initial assessment.

The assessment process is based on a number of principles, including the process of decentering, the recognition of multiplicity, and the acknowledgement of the role of power relationships in the therapeutic encounter (Rousseau, 1998).

Essential to this work is a recognition of psychiatry's own cultural biases (Littlewood, 1986), the elaboration of multiple meanings of difficulties and their possible solutions, and the negotiation and mediation of underlying tensions in therapeutic encounters (Kirmayer, Rousseau and Santhanam, 2003; Measham, Rousseau and Alain, 2003).

The clinical result has been a reformulation of the therapeutic setting, both physically and symbolically, in a manner that invites a complementarity of knowledge systems in order to elicit a multiplicity of viewpoints concerning how a problem is perceived, understood, and responded to. Examples of these viewpoints include but are not limited to the individual, collective, professional, spiritual, traditional and socio-political. Participants in the evaluation are able to interact with a team that represents multiple aspects of identity. The collective group may also provide a containing and reassuring environment. At the same time, smaller groups or one-on-one interviews are held in particular situations at the time of the first meeting, for example when the team is meeting with unaccompanied minors or when the collective group meeting is noted to produce tension for a child or his or her family. Following the assessment the team meets briefly to discuss their impressions and treatment plan. Feedback is given to the patient, their family and the referrer at the time of the evaluation, with the family and referring party being included in the treatment planning.

Standard western psychotherapy and pharmacotherapy techniques are offered to children and families, as well as treatment techniques that have been more specifically developed for the team's clientele. The latter include individual therapies such as sand play therapy, traditional storytelling therapy and art and drama therapy. Family therapy modifications include family therapy with culture brokers and extended family councils, as well as the introduction of transnational social networks both in the imagined space and also if possible and wished for by families by letter, email or three way calling. Treatment efforts also explore other modes of care being practiced by the family including traditional or religious care, and if appropriate this care is integrated in the service's treatment plan as a central, complementary or parallel modality of treatment. Finally, team members consult and mediate with institutions, chiefly including schools, health and social service providers, and immigration and legal services.

THE THERAPEUTIC ENCOUNTER:

EXAMPLES OF TREATMENT MODALITIES

The Service's Approach to the Disclosure of Traumatic Events in the Treatment of Posttraumatic Responses

As a result of its clinical experience with refugee youth, the team questions the efficacy of the disclosure of horrific events as a necessary therapeutic tool for healing in all experiences of trauma. Current team practice involves a recognition of the particular and sometimes conflicting needs for disclosure among different family members. The individual and collective meanings of trauma as well as the value of disclosing trauma as a means of healing are considered important to elicit.

Methods used by the team to allow patients and families to both approach and maintain a distance from the past in their elaboration of meaning around traumatic histories can lead, for

example, to multiple concurrent individual and subgroups of therapies for different family members. Treatment modalities found to be particularly helpful by the team to support this approximation and distancing to trauma include the use of traditional storytelling (Bagilshya, 2000) and the creative arts therapies (Lacroix, 1998; Heusch, 1998). The introduction of traditional therapies and spiritual care within the therapeutic space, as well as the use of non-verbal means of communication in psychotherapy, such as writing, novels and poetry are also used in treatment.

Case Vignette 1: “Agnesa”

14-year-old Agnesa was referred for psychotherapy by her school because of sadness and learning problems. As a result of conflict in her country of origin, she had had little opportunity to attend school before fleeing for Canada as a refugee when she was aged nine. During the family assessment, Agnesa’s mother shared that her children were becoming increasingly wishful of discussing their homeland with her, and they also wanted the family to speak their mother tongue together, which the children were losing. Mother could not bear this, as it brought to her mind the loss of her relatives. Agnesa was found to have a posttraumatic stress disorder and depression. Mother shared that she also coped with chronic suicidality, while she did not wish for therapeutic support. Agnesa was offered individual creative arts therapy, where she would frequently create pictures of an idealized homeland. In family sessions, mother began talking of her wishes that her daughter succeed in school. With this she also began to recall proverbs in her mother tongue which her own mother had told her to help her learn. Agnesa’s depressive symptoms and school functioning began to improve, while mother also began to engage with community workers providing psychosocial support to the family.

This vignette illustrates the therapeutic work around supporting family members in their reparation of traumatic experiences. Mother’s avoidance of all aspects of the past with her children served a protective function for her, while the children were cut off from their culture of origin. Agnesa in particular expressed more interest in this as she entered adolescence. Mother and her children found proverbs to be a way of transmitting aspects of the family’s cultural past which helped Agnesa invest in her future. This working around as opposed to through their traumatic history also served a protective function for mother in her own suffering, as it linked her to a past before her own experience of violence. It is seen as the beginning of a modulated disclosure around traumatic issues, where the role of parents as gatekeepers of a family’s past is recognized (Measham, 2002).

Work with Families: A Reconfiguration of the Therapeutic Space to Negotiate Between Multiple Universes of Meaning and Action

Another particularity of treatment is a reformulation of psychiatric treatment modalities in terms of the representation of the individual and the collective in the therapeutic process. Thus, dyadic therapy is sometimes reconfigured as triadic therapy, where an interpreter or another team member work together to represent part of the negotiation of the therapeutic space between the values and traditions of the host country and the country of

origin. This opening of the therapeutic space aims at representing and acknowledging the legitimacy of multiple worldviews of the meanings of children’s difficulties and the necessary actions required to alleviate children’s distress. In addition, recourse is made to collective in addition to individual and family means of understanding and resolving disputes, such as the convocation of family councils and the inclusion of traditional authority figures acceptable to the family such as spiritual leaders in order to address difficulties.

Case Vignette 2: “Guillame”

Guillame is a 13-year-old boy with mental retardation and behavioural problems who is of African origin. During a conflict Guillame threatened to hurt his mother with a knife. The family was referred for consultation as they did not wish for Guillame to be placed outside of the family, as had been offered by their treating team, while there also appeared to be few avenues available to improve Guillame’s behavioural difficulties. During the team’s assessment the family put forward different overlapping explanatory models for Guillame’s problems. These included his low cognitive abilities and his epilepsy. These models converged with the host country’s explanations for his difficulties. In addition, the presence of a psychologist of African origin on the service allowed other meanings to emerge. The family reported that they were afraid of Guillame because of the presence of a black magic spell currently possessing him. The family reported that traditional avenues for treatment were available for Guillame in Africa but not in Montreal. The isolation of the family in Montreal was considered to be a key factor in the family’s inability to handle Guillame’s behavioural crises. As a result, this fear was longstanding, and it was interfering with their ability to appropriately manage his behavior.

Part of the treatment involved the convocation of a traditional family council with all of Guillame’s adult relatives to discuss the problem. In outcome, Guillame’s family consulted their extended family in Africa. The family decided to seek a traditional treatment in Africa, in addition to continuing with a pharmacological treatment of his epilepsy. The traditional treatment was seen by the family as an important step to reintegrate Guillame with his family and to empower them in their role to structure his behaviour. Ongoing support would be provided by host country health and social services on his return.

This vignette illustrates how the treatment process, including the convocation of a family council, introduced a collective aspect to address Guillame’s difficulties which sought the broader support of Guillame’s extended family in Montreal and Africa. The family then developed a treatment plan that utilized cultural knowledge and resources along with biomedical and psychosocial interventions.

Training and research activities provide a means of questioning, multiplying and disseminating knowledge both at the institutional and at the community level. Students from many disciplines are clinically trained on the team. Students are also able to participate in other clinical and research teaching offered by McGill University’s Division of Social and Transcultural Psychiatry. This includes, for example, the courses and seminars offered in the annual Summer Program in Social and Transcultural

Psychiatry, or for students pursuing research training, the program offered by McGill University's MSc degree in Psychiatry. Finally, graduate and postgraduate training for researchers from diverse health and social sciences backgrounds can also be undertaken through the McGill-CIHR Strategic Training Program in Culture and Mental Health Services Research.

The design and the evaluation of novel and standard forms of intervention and prevention is an important area for clinical research in transcultural child psychiatry, as the literature on empirically tested interventions of standard and novel child psychiatric treatments with refugee youth is sparse (Lustig et al., 2004). There is an absence of the evaluation of treatment methods such as cognitive behaviour therapy for posttraumatic stress disorder or pharmacotherapeutic treatments specifically among refugee youth, and evaluative research on novel treatment models designed specifically for refugee youth is also needed.

A review of the 239 cases seen by the Transcultural Child Psychiatry Team between July 1996 and December 2000 provides a descriptive analysis of the characteristics of families requesting services and the evolution of the clinical relationship (Measham, Nadeau, Rousseau et al, 2001). An analysis of the rates of retention from the initial referral to the first appointment and beyond showed that the largest rate of dropout (15%) occurred prior to the first meeting. Once a family attended a first appointment, 74% remained in treatment until its completion or were currently still in treatment at the time of the study. A qualitative retrospective evaluation of trauma cases (Foxen and Nadeau, 2001) and of psychosis cases (Rousseau and Key, 2001) describes the characteristics of the clinical interventions of the Transcultural Child Psychiatry Team's in these clinical situations. Finally, a prospective, qualitative evaluation describes the evolution of feelings of otherness and power relations in the request for clinical services and in the therapeutic process (Nadeau 2003).

CONCLUSION

A review of the development and clinical experience of the Transcultural Child Psychiatry Team shows a specificity related to the team's clientele and to its methods of functioning and treatment. The team developed as a superspecialized service within an academic setting and tertiary care hospital where it has been able to develop new care practices for immigrant and refugee youth in a combined teaching, research and clinical setting. At the same time, the team's downtown location in a specialized university hospital setting has limited its ability to support families regionally by intervening on multiple levels, including in their schools and neighborhoods. As a result the team has begun to shift its functioning by offering consultation and ongoing support to children and their families in proximity to their local neighborhoods. This has resulted in preventive health services being offered in Montreal's multiethnic schools, as well as consultation and training services in community clinics and at child welfare institutions (see Rousseau's and Nadeau's accompanying articles in this edition). A parallel movement has been the team's increasing growth towards conducting evaluative research of its intervention and prevention work. A goal is to be able to evaluate our current models of care, including our

developing consultation model of community interventions. This movement of the team beyond the margins of a specialized health care setting is introducing new and interesting collaborations and exchanges between patients, families and institutions.

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