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AN ASIAN CANADIAN MAGAZINE VOL. 6 NO. 1 SEPTEMBER/FALL 1984

MENTAL HEALTH

MY EXPERIENCES AS A VIETNAMESE DOCTOR *by Bach-Tuyet Dang*

ASIAN CANADIAN PSYCHIATRIC PATIENTS *by Teri Chan*

WHY IMMIGRANTS USE TRADITIONAL THERAPIES *by R.D. Chandrasena*

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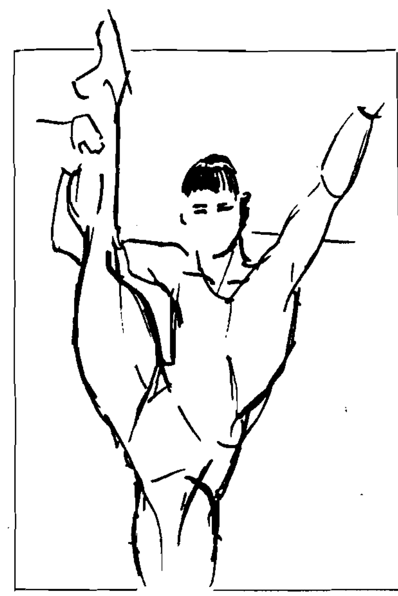

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EDITORIAL

Asian Canadians and Mental Health

The issue of good mental health care for the Asian community in Canada has long been of great concern to me. Fifteen years ago, mental illness was not considered an appropriate topic of conversation among my family and friends. Rather, anyone who had a family history of mental illness denied any knowledge of the situation, because to admit to it would mean "losing face" in the community.

Only recently, within the last five years, have I been aware of a growing interest by a few professionals that mental health services and education for Asian Canadians are needed and welcomed. Many of those same professionals devote much time and energy to improving the lot of Asian Canadians who are mentally ill, have emotional problems, or who have recently emigrated to Canada and are experiencing adjustment difficulties.

This special issue of *The Asianadian* has contributions by this group of hard-working and caring individuals in the mental health field. Special thanks to Dr. Peter Chang and Kathy Wong for their help and cooperation on this worthwhile and exciting venture.

Teri Chan

Need for Recognition

While it has become fashionable in some circles, notably the Hollywood set, to have a personal psychoanalyst to help solve all problems of living, for the majority of people, mental illness continues to carry a shameful stigma. At cocktail parties, one often witnesses show-and-tell sessions on surgical scars, yet emotional scars remain deeply hidden.

Among Asian cultures, mental illness is even less acceptable. This communal rejection has led people to consciously as well as unconsciously deny the existence of any problems. As a result, patients often camouflage their real symptoms, making the diagnostic process even more challenging than it already is.

On the other hand, mental health professionals have to tread carefully when discussing mental health issues in public, as it is a cardinal sin to be seen to label any ethnic group as being prone to mental illness. But the most important step in solving any problem is accurate perception. We have to see ourselves as we are, not any better or worse than other races. The Asians are just as likely as other people to develop mental health problems.

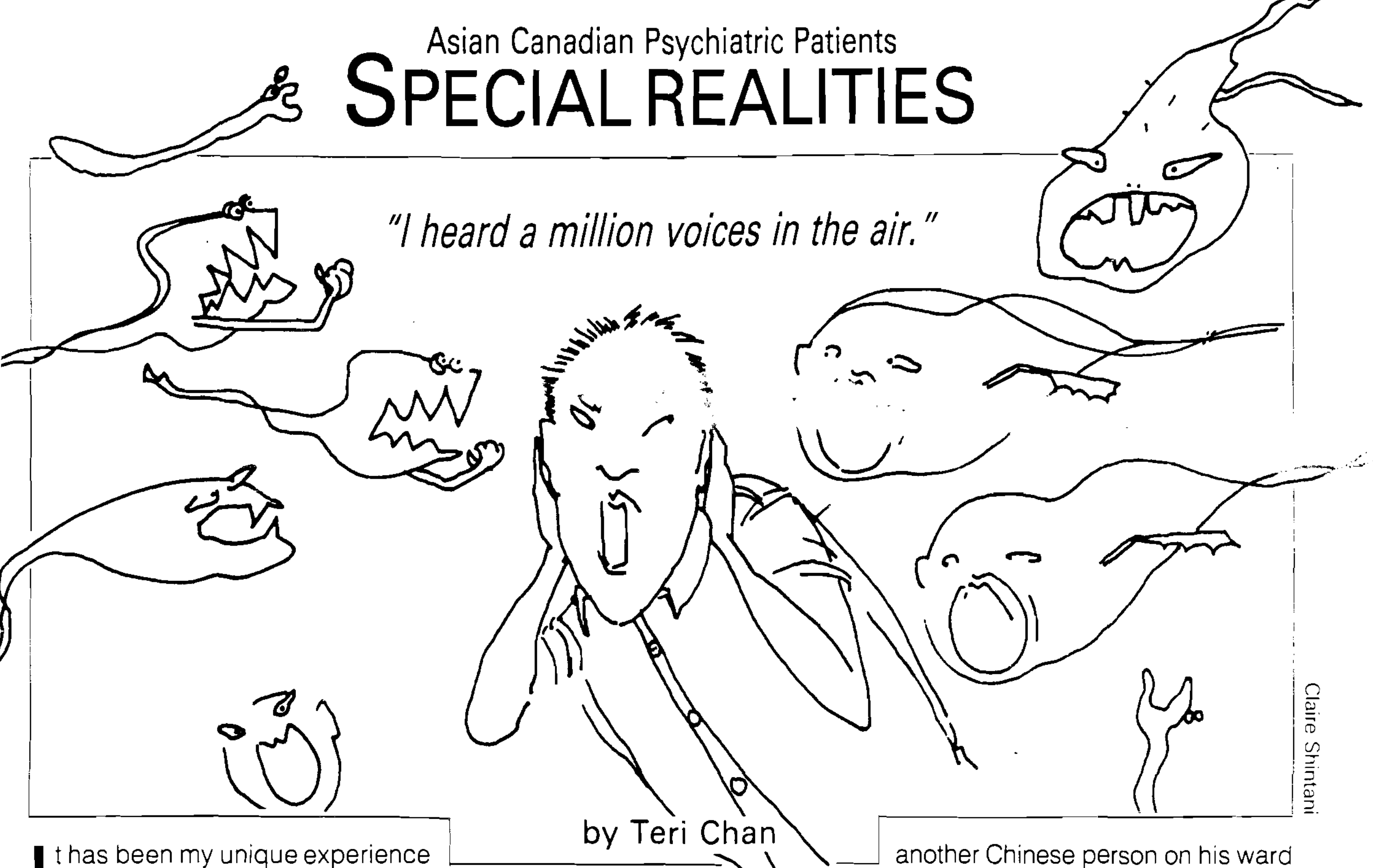
We hope that this special issue of Asianadian on Mental Health will go a long way towards demystifying mental illness, and encouraging further public discussion on the subject.

Peter Chang

Asian Canadian Psychiatric Patients

SPECIAL REALITIES

"I heard a million voices in the air."



Claire Shintani

by Teri Chan

It has been my unique experience to teach three very special Chinese-Canadians in a classroom setting in The Clarke Institute of Psychiatry in Toronto. Over the past ten months, there has been a great deal of sharing, learning, and problem-solving together. This has resulted in poetry, artwork and the personal histories of these three individuals. Their experiences as psychiatric patients and as Chinese-Canadians have both similarities as well as differences. Two are outpatients and one will be leaving the hospital soon.

HAROLD

As an outpatient, Harold has spent the least amount of time with me. But in that short time, he has executed several drawings and told me the story of his illness.

Harold was diagnosed as a schizophrenic when he was 23 years old, four years ago. Born in Toronto, Harold attended a technical school up to grade 10 and also spent less than 4 years in a Chinese school. Up until he became ill, Harold was employed as a garage mechanic and lived at home with his parents and seven brothers and sisters.

His first incident, which led to his hospitalization at the Clarke Institute, happened while he was sitting at a bus stop after work. "I started hearing voices and from then on that night, I heard a million voices up in the air. So, I asked a friend of mine to drive me up north to see if I could get rid of the voices." However, his friend thought Harold needed help and he was subsequently admitted to the Clarke for three months.

Prior to this incident, Harold recalls feeling paranoid, hearing voices and seeing things. "I was seeing black splotches flying through the air and surrounding me, mostly at night. They were frightening – I didn't know what they were." He was also paranoid around other people and stayed at home most of the time.

After a while, the voices stopped with medication. While in hospital, he felt frightened for the first month, but therapy and group sessions helped to alleviate this fear and he received a lot of support from the nurses. He also met a Chinese-speaking patient on his floor. He felt a little better knowing there was another Chinese person on his ward to talk to.

Upon discharge, Harold went back to work at a different shop but was fired from that job and another one after that. He was readmitted to the Clarke four or five times, each stay lasting two to three months. He was always admitted for the same symptoms and for depression as well. The medication made him feel tired and non-motivated. During his depressions, he would just sleep it off, staying isolated at home and not contacting any friends.

At the Clarke, Harold participates in a day-care program that includes ceramics, newsletter, social group, volleyball, weight-lifting and medication group. In the medication group, the patients discuss reactions and side effects from certain medications. They also give each other support and feedback, a very important function of the group. "I always tell them that it's painful when there are a lot of side effects, but the medication is worth it in the long run."

Harold comes from a large family of three brothers and four sisters – he is the second youngest. Both his parents were born in Hong Kong and he feels that his "parents never

really knew how to help me, or the right way to communicate with me at the time. They were just there. They felt it was a big scandal because they weren't too sure why I was sick." They couldn't relate to the kind of illness that Harold had, an illness that was emotional rather than physical.

His sisters and brothers were generally supportive and spent a lot of time with him. Also, his grandmother was aware of his illness and provided much support. "She used to take care of me when I was a kid. She lives by herself and we see her on special occasions. She asks me if I'm eating properly and keeping healthy. The understanding of my parents and family is better now about my situation."

"At first, my parents didn't want me bring home anybody from the Clarke. They think they're all crazy people and didn't want me associating with them. But I do bring friends home now and my parents appreciate it more. I have one good friend who was admitted at the same time and we see each other once a week, as well as a few of the other patients."

When asked about his parents' religious beliefs, Harold affirmed that there was some element of religion at home but it was not definable. He recalls that "they were pretty spooky to me. They'd hang up pieces of bark. My mother would make a cross out of it and hang it over my door. I told my mother to take the cross down. But she refused, saying it would keep the bad spirits away."

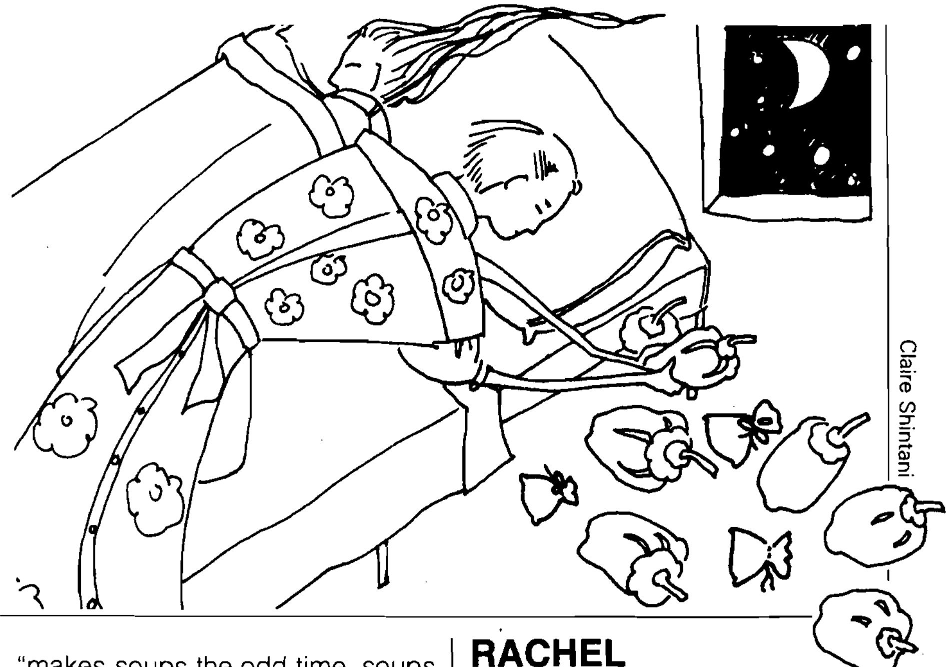
Mother used to say it was the bad spirits that made him ill. "She would put the cross up when I was sick. She also wanted me to wear this necklace that she had, which had something to do with Buddhism. She's not really Buddhist, but she thinks really weird things. My father wouldn't do any of these things, but he would go along with it. They would burn incense for people that had passed away, but that's not spooky."

Harold adds that his mother "makes soups the odd time, soups that taste horrible, very bitter. I used to drink them when I was a kid, but now that I am older, I never touch the stuff. My mother gets upset and says that I'm going to get sick. She doesn't give up and tries all the time".

Of his future, Harold remains optimistic. "I'm still living at home, but I'd like to move out and be more independent, cook for myself, stuff like that. But I can't afford to go on welfare – the rents are too high. And I would like to work part-time because I don't think I can handle an eight-hour day. My welfare worker thinks that it was the fumes that were getting to me. Some days, I would feel physically ill. Maybe, I'll work as a car jockey. I like being friendly with people. Depending on how I feel, I try to bounce the happiness in me onto somebody else and see how they react."

Last week, Harold was fired from his new job in a well-known muffler shop. One of the side effects from his medication produces involuntary movement in his lower jaw. His employer told him that the movement was not acceptable because he was dealing with customers.

And so Harold continues to see his friends and to take part in a myriad of day-care activities in the hospital.



Claire Shintani

RACHEL

Only twenty years old, Rachel has been an inpatient at the Clarke for the past five months. She was born in Toronto and has completed grade nine. A soft-spoken young woman, she tells me that her illness began "when I started grade nine and began seeing a psychiatrist. There were some family problems and I got really carried away. We had to move to a new house and my grandmother had just arrived from China to live in Toronto in her own apartment. And Dad was gambling. There were a lot of family problems.

I had heart palpitations. So, I had to take stellazine and was in Sick Kid's Hospital for a few weeks. Then I went back to school for a while, and was admitted to Sunnybrook Hospital. Again I got better and went back to school. I got along well and participated in dance performances, volleyball and gymnastics. But after taking medication, I used to be very tired and my mother told me I should rest. So I didn't do my homework and I got side-tracked, I guess".

Altogether, Rachel has been in psychotherapy for the past six years. She has been diagnosed as a manic-depressive.

Of these early experiences as a psychiatric patient, Rachel says: "I

was frightened that I would never get out of hospital. I got more suicidal. I tried five or six times to commit suicide because I hated my family and felt ugly.

I felt my family hated me because I was so quiet and well-behaved. I think they were just jealous of me and my friends too. I had everything going for me in the past – guys liked me and Mom did favour me".

Rachel is the second youngest in a family of four daughters and one son, who is the youngest. Says Rachel of her younger brother, "My Mom had to have a son and he's ill now. He's been in Sick Kid's, Youthdale and Sunnybrook. I worry about him – he's so young". She agrees that he has similar problems and patterns in terms of his illness.

When her parents first found out about her illness, they burnt incense and put red powder in a little bag and placed it under the bed. The meaning of this was never explained to her. "Mother made a lot of food with herbs or herbal remedies, to help me get better. She felt that the prescribed medication was all right and encouraged me to take it. Dad tries to be understanding, but doesn't say too much".

On a recent occasion, Rachel's mother and grandmother prepared a special vegetarian meal and burned offerings later on. A red shrine with the Buddha is located in the kitchen, a mirror hangs in front of the house. Rachel's mother puts pennies under the bushes with orders not to remove them. Rachel feels her mother has many superstitions.

Rachel and her brother have their own special rice bowls, larger than their sisters'. And both are expected to eat more for good luck. "Mom has many things for good luck", she comments.

The rest of the family, aunts and uncles, have not been told of the two children's illness. The parents keep up the illusion that all is well and that Rachel is still attending school, as before.

To date, Rachel has had 24 E.C.T. (electric shock therapy) treatments and she feels better. "I'm not suicidal in my mind anymore and I feel positive. I don't know why. I always laugh and giggle a lot more. My family likes my sense of humour. After a treatment, it takes me about two weeks to feel normal again.

Right after E.C.T., you feel like lying in bed all the time and I couldn't go to school (in the Clarke) for a while. And you don't eat and you lose weight. You feel very depressed after E.C.T. It takes a couple of days to feel better, with support from family, friends, teacher and psychiatrist. I'm taking Lithium, Haldol and Chemedrin."

As part of her day-care program at the Clarke, Rachel is involved in volleyball, school, discharge group, drug group, music group and projective art. "Sometimes in projective art we do a painting or cut and paste – a collage. It's really fun because the theme was 'What Makes You Happy' and I chose 'Lying on the Beach'. There is also ward meeting, pottery and film groups.

I like school the best. Process group is very helpful. We discuss problems as a group and my doctor is there too. We discuss a problem, decide what to do, sort it out, talk and communicate and progress. I also like creative writing, poetry and games with themes like 'happiness'. And I have good rapport with my psychiatrist. I trust him and have complete confidence in him."

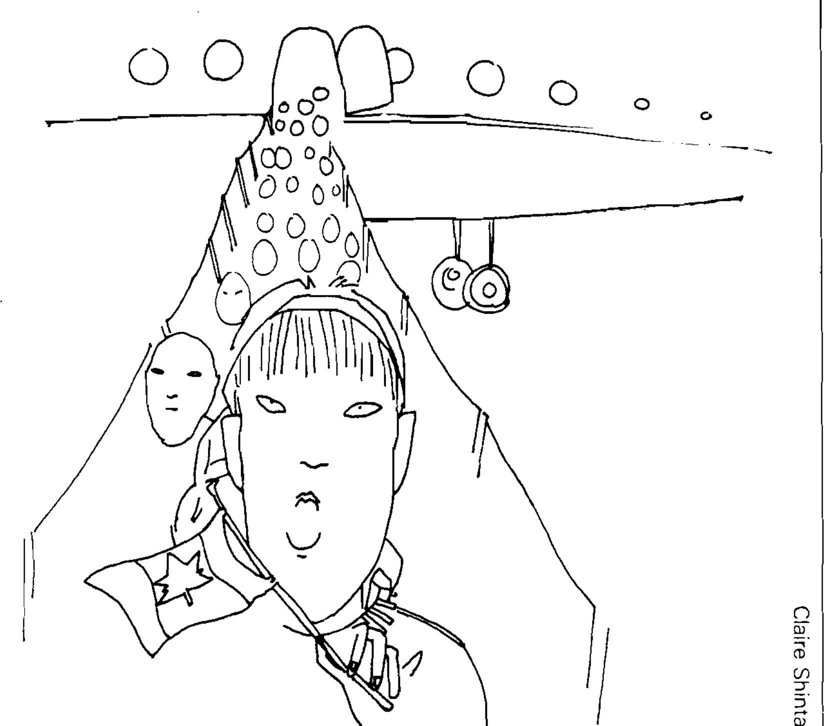
On weekends, Rachel visits with her family at home. She likes to cook, especially with her father and help out at home.

In her school program, Rachel has worked on a review of math, written many beautiful poems about love, friendship and disappointments in her life. And she has been prolific in her delicate, precise artwork, mostly of flowers and birds, derived from her love of Chinese painting. We have also shared the exprience of seeing a Chinese art exhibit in a local gallery.

Soon Rachel will be leaving hospital and moving into a group home, from which she will continue her daycare activities here at the Clarke.

Claire Shintani

"When I first came to Canada I felt like a nobody"



Claire Shintani

EMILY

Emily is a thirty year old outpatient, who is single and has lived in Canada for ten years. Emily emigrated here from Hong Kong, where her illness had begun over eleven years earlier. She is a shy and demure individual, who can be very effervescent when she is happy. She speaks with a discernible accent. She has been working diligently to improve and expand her English language skills during her one-and-a-half year period in our classroom at the Clarke.

Emily described to me the circumstances of her illness when she was nineteen years old and living in Hong Kong with her mother. She remembers that she had difficulties in school and was becoming ill. "Mother noticed something was wrong with me. Maybe I talked to myself and I was telling people that someone was following me and I was feeling insecure, that someone would catch me. My sister didn't believe me, but my mother took me to a doctor and I stayed in hospital for one month. I felt the same after my discharge. It was a difficult, unpleasant time."

Her mother was not communicative about Emily's illness. Emily stayed with her, relatively isolated, never going out or seeing anyone except her doctor.

Then, Emily emigrated to Canada with her mother, sister and brother. Her parents had been separated for several years. At first, it was difficult because she stayed with her older brother and sister-in-law. The latter was unhappy because Emily had no income and could not contribute financially for her room and board. But Emily did manage to go to school (for immigrants) and learn some English. She stayed for a year with her brother.

"When I first came to Canada, I felt like a nobody, with no friends. It was difficult because I was still young and naive about life". However, she did have a letter from a Hong Kong doctor and her sister-in-law found a psychiatrist for Emily to see. Since that time, she has been hospitalized twice, for a period of a month each time and has seen three psychiatrists up to the present time.

Recently, she changed psychiatrists. She now sees a woman Chinese psychiatrist once a week and is seeking the reassurance and advice she needs. Emily feels more secure to have a psychiatrist who speaks Chinese, even though not the same dialect. "I feel I can say more things to a Chinese person than a Canadian, and there is a better cultural understanding".

According to Emily, her mother has no known religion or superstitions. However, many years ago Emily became interested in Christianity and this has become a part of her life. She doesn't feel she is a "dedicated" Christian, but she attends church socials, Bible study and Sunday services. Emily likes the Bible study class the best, because she learns something each time, even though she finds the English difficult to understand. This church group is all-Chinese and Emily is the oldest member, with the youngest ones around twenty.

Emily's mother doesn't talk about her illness any more but only advises her daughter to keep healthy physically and to eat well. Emily feels that her sister-in-law, on the other hand, is often non-supportive and critical in her attitude. Emily finds this difficult to deal with on her sister's occasional visits to the family.

Emily feels proud of her Canadian experience because she has learned more about life here. In Hong Kong she led a quiet, isolated existence. And learning English in the school setting has helped her a great deal. She is now working in a temporary work station set up by the Work Adjustment Program at the Clarke.

"I do coding, posting, checking, filing, writing service advice forms – step by step, they gave me more things to do." Even though the tasks are easy and repetitive, Emily likes her job. "I like having a job to go to in the morning – something to get up for. Otherwise, I have nothing to do. I sleep in and it does me no good. And I am managing to get along with a lot of people. They are really nice to me."

Emily wants a permanent job for at least two years at the Clarke if she can get on staff full-time. She also attends a "work group", which is helpful. The group discusses such issues as "How to Deal with Negative Feedback". It is part of Work Adjustment's support program for job station employees/outpatients.

Among her other activities, she has taken badminton classes and is looking forward to learning how to lift weights with her volunteer contact. The volunteer arranges to participate in social activities with Emily on a regular basis. She is considering her volunteer's health club, because the exercise will "shape her up".

When asked about how she felt about having a Chinese person as her teacher, Emily replied that she "felt comfortable. I can relate to you more and it helps me a lot". Emily has attended our school program for the past year and a half and then moved on to the job station. We have a short weekly visit when she comes to the Clarke for her group session.

After several years in Canada with a history of illness, Emily now has friends, a church group, a job and an active social life. The team of professionals at the Clarke are very pleased with her progress and her increased ability to function well in this society.

It is a daily struggle for Emily. But one day she hopes to get married and have a family, and she works enthusiastically towards that goal. ▲

Mental Illness and Traditional Chinese Medicine

Jack Seto

Traditional Chinese medicine dates back to over 3,000 B.C. and still has a pervasive influence over a large population, not only in China and Asia, but also in the immigrant Chinese population in all parts of the world.

In the *Yellow Emperor Annals of Internal Medicine*, the first important medical treatise in China, various conditions were described, including 'head ailment' and 'heart ailment'. From a Western perspective, these would be considered emotional disorders. However, psychiatry as such never developed as a specialty in Chinese medicine. The psyche is very much considered as part and parcel of the holism of the person. The Cartesian mind-body dualism is not seen as in the West.

In fact, seven emotions are seen as important "internal factors" contributing to ill health, but the manifestations include both somatic as well as psychological symptoms. The treatment is aimed at restoring the balance through various dietetic practices, herbal remedies and acupuncture, as it is for physical problems. The traditional Chinese physician may offer some common sense advice as to the conduct of the patient's daily life, but psychotherapy is a treatment modality never recognized.

Mental illness in traditional Chinese medicine only include the most severely disturbing cases classified as:

Tien: the passive, and withdrawn patient who has lost controls with reality, not dissimilar to some types of schizophrenia, colloquially the term also refers to people who are crazy, not knowing what is what.

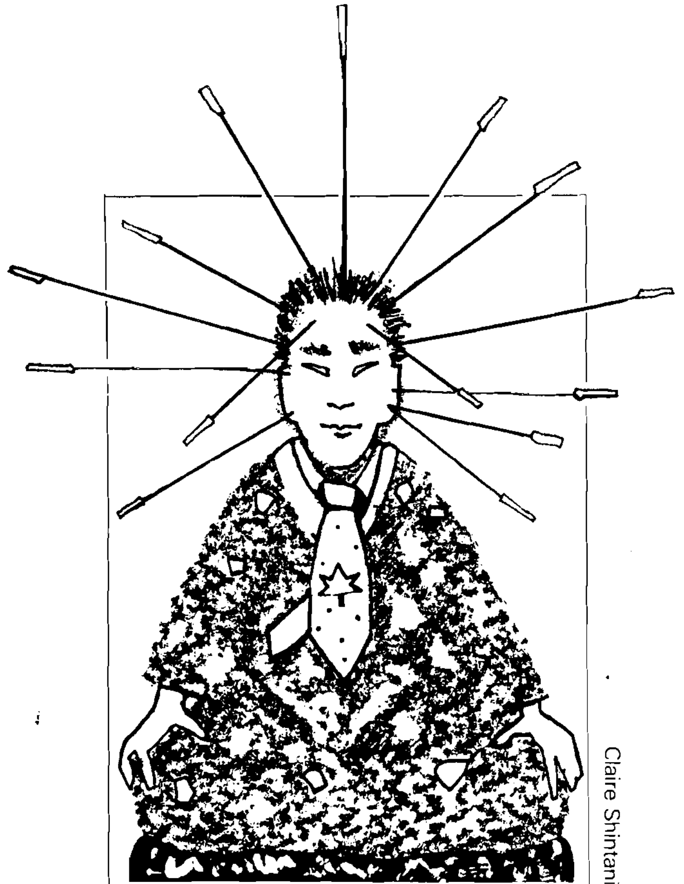
K'uang: the agitated and rowdy patient who might be considered hypomanic in the West. This term is also used colloquially to denote somebody who is very excited.

Hsien: these are episodic disorders equivalent to seizures in the West, where it falls more into the domain of the neurologic.

This is just a brief glimpse at the concepts of mental illness in traditional Chinese medicine. For those interested, Dr. K.M. Lin has written an informative chapter is *Normal-Abnormal Behaviour in Chinese Culture*, edited by Arthur Kleinman and Thug-Yi Lin (published by D. Reidel Publishing Co.). ▲

Ted Lo

TRADITIONAL THERAPIES


Claire Shintani

Why Immigrants Seek Them

by R.D. Chandrasena

Among the valued possessions immigrants bring with them when they move to Canada is their cultural heritage. Culture shapes human behaviour, thinking, and attitudes, and the responses to illness are an integral part of culture. While these cultural patterns of behaviour may lead to conflict at times with those of the host nation, they also serve a very useful function which helps immigrants adapt to a home away from home and minimize the "culture shock" due to the migration process.

The therapies people seek for ailments are an important part of cultural behaviour. It is often possible, at least in part, to satisfy the immigrant's culinary needs, entertainment, recreational activities, and special educational needs, within the existing social structure of the host nations. However, traditional therapies for ailments have not been thought to play an important part in the sub-cultural activity amongst immigrant groups.

Although the roots of medicine as practised today in the Western countries probably date back to the time of Hippocrates, it is a relative novelty in the developing countries. The practise of Western medicine was introduced to the developing world during the time of colonisation over the past 200 years. This period was preceded, for thousands of years, by traditional therapies varying from ingestion of herbs and decoctions to the practise of spiritual and religious rituals to cure the sick.

A recent World Health Organization report states that although most developing countries spend a disproportionate amount of money on Western-oriented health services, the traditional therapies still provide by far the bulk of primary care. However, Western nations do not see these therapies as an important part of health care for immigrants. There is a belief that Western medicine is always superior to traditional therapies. Traditional therapies are equated to quackery. An established system offering these types of therapies, as an alternative to Western medicine does not exist. This has led to the development of an "underground" health care service for such immigrants.

Psychological ailments have traditionally had a variety of explanations based on mysticism, fatalism, and supernatural phenomena. The inability of immigrant groups often to relate to the Western system of mental health care has led to the *hakims* and *Obeah men* and such-like to see to the unmet needs of the immigrants. Western governments have traditionally ignored the existence of these health care professionals within their societies and often scorned them when they came to their notice.

Medical schools hardly ever teach students of alternatives to Western medicine, and research into the efficacy of traditional therapies in a scientific manner is uncommon. The notable exception

to this, however, is the evaluation and subsequent establishment of acupuncture over the past two decades in the West as a useful therapy.

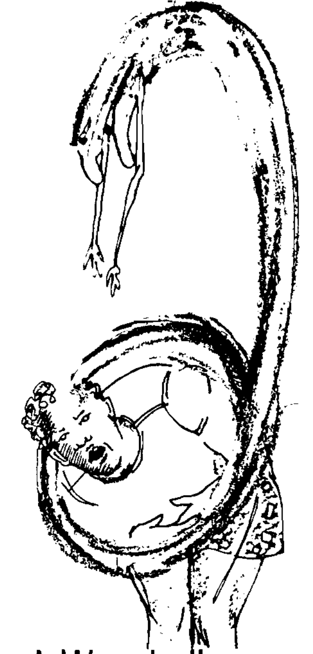
If it is likely that immigrants practise alternatives to Western medicine, then one may question as to what alternatives are available among ethnic minorities. How often are these alternatives used? How efficacious are they? What are the implications of such practises for planning of health care services of immigrants?

In an attempt to answer some of these questions, I carried out a study in the United Kingdom where a group of mentally-ill hospitalized patients were studied. Over 200 patients were systematically queried as to what alternative treatment they sought prior to their being admitted to hospital.

The patients were divided into three groups: Afro-Caribbean, Asian, and "Native British" (Anglo-Saxon). All therapies recommended by doctors, pharmacists and self-medications obtained from drug stores were classified as "Western", herbal remedies, use of decoctions, rituals, and religious practises to cure the sick, and all treatments recommended by *hakims* and *Obeah men* and other traditional healers were classified as "traditional therapies".

The traditional therapies had to be used moderately or extensively to be included in the study, as will be noted later. Duration of illnesses prior to hospitalization, the number of previous hospitalizations, the duration of total hospitalization, were obtained and the results were compared with few available other studies.

The study showed that a significant number of patients from ethnic minorities tended to seek traditional therapies prior to coming into contact with Western medicine. 66% of immigrants and 20% of the British group had had contact with "traditional therapies". The duration of illnesses among the immigrant groups was longer, and the patients stayed longer in hospital and had more frequent hospitalizations. Adverse reactions to traditional therapies had occurred, and the literature documents many such reactions.



Claire Shintani

A West Indian man thought that the pain in his stomach was his dead father's spirit burning his abdomen

The following clinical vignettes illustrate some of the traditional therapies used by the study group.

A 54-year-old West Indian man, who had had abdominal pain for about 5 years due to chronic gastritis on account of his heavy drinking, developed ideas that his pain was due to his dead father's spirit burning his abdomen. Over a few months, he became increasingly convinced of this belief, and sought a priest to exorcise the dead spirit.

The priest sprayed holy water, and with a wooden cross made several attempts to rid the house of the spirit. The patient felt only short-lived relief from the pain, and subsequently wrote to a faith healer, who, for a sum of nearly $75.00 sent him a ring to wear. It was nearly a year after the origin of these beliefs that he was referred to a gastroenterologist by his family practitioner.

A 21-year-old Indian girl, over a period of two months, showed a gradual deterioration of social function. She became unkempt, less communicative, and would spend increasing amounts of time in her room in isolation. She was seen to laugh and mutter to herself. The parents consulted her horoscope, which indicated that the age 21-23 was a bad period, because of unfavourable planetary disposition.

A *hakim*, who was visiting from India, was consulted, and the *hakim* confirmed the astrological explanation, and prescribed some medication which cost over $250, as it had to be shipped from a factory in India. The patient started therapy two months later, and over a few months of treatment there was some gradual improvement noticed. Nearly a year after the patient's onset of illness she had not recovered, and was eventually referred for psychiatric assessment.

How are we to interpret the results of the study meaningfully? The prevalence of traditional therapies as a primary choice among immigrants when they fall sick is to be expected. Sub-cultural beliefs often determine behaviour.

It is understandable, as documented in the World Health Organization Report, that the majority of patients from developing countries receive most of their health care and especially primary health care from traditional healers. Efficacy of the kind of therapy carried out by these healers cannot be evaluated, as they have not been subjected to rigorous scientific testing. However, they cannot be dismissed as being ineffective, nor can any improvements from them be attributed to true efficacy. It is well-known in medicine that there is a significant "placebo" effect in whatever therapy the patients practise.

What appears to be important is that due to the patients seeking traditional therapies, there is a significant delay in their seeking Western medical care. During this period it is possible for patients to develop

adverse complications, and, therefore, subsequent management is made more difficult. Further, traditional therapies, because of the inherent nature of the ingredients used, may cause adverse reactions. For example, herbal tea containing Chamomile flowers is often used as a sedative, relaxant, for relief from pain, and as a general tonic. This type of tea is known to have caused allergic reaction such as severe anaphylaxis, or sesnsitivity to ragweed pollen or caused extensive vomiting.

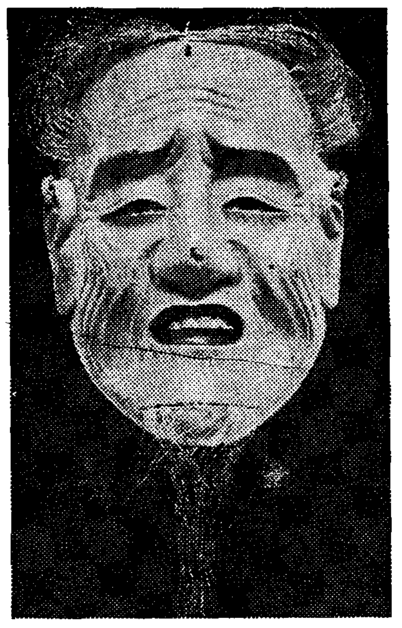
Although the sample of patients studied were hospitalized, and, thus, had not been "cured" by the traditional therapist, a significant number of the group claimed that they had obtained partial relief. A proportion of them even stated that they wished to return to the traditional therapist should they fall ill again. These attitudes were seen to be partly due to the traditional beliefs associated with immigrants, and the treatment process being culturally more acceptable to them than the Western system of mental health care.

It is possible that these patients obtained partial relief from the use of certain yams and decoctions, as they are known to contain powerful psychotropic ingredients, such as Reserpine.

It is interesting to note that the patients had sought traditional therapies in spite of their cost when the Western treatments were available free of charge. The patients stated often that the initial stages of the illness were not indeed seen as an illness. Instead these stages were interpreted in terms of cultural beliefs and taboos, and were explained away in various supernatural and fatalistic terms.

Therefore, the obvious choice was to seek traditional remedies which had "explanations" for such occurrences, and the nature of the illness became evident only subsequently. What was apparent was that cultural values, indeed, die hard.

It is well-documented that among immigrants there is a higher incidence of mental illness, especially the major psychiatric disorders, such as schizophrenia, manic depression, alcoholism, and drug dependence. These data are often based on hospital admissions of immigrant groups and their comparisons with Western patients.



There is a higher incidence of mental illness among immigrants

My study also showed similar results in that the patients who were studied had longer illnesses, had had more frequent hospitalizations, and total duration of hospitalization were longer. However, I have chosen to interpret these results differently, as it is clear that immigrant patients seek alternative therapies prior to coming into contact with Western medicine. Therefore, there appears to be a selection of the chronically-ill group of patients who are repeatedly admitted to hospital.

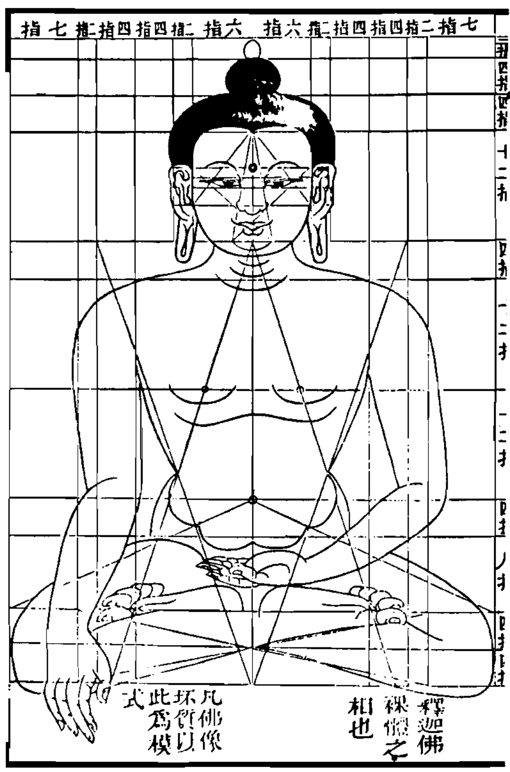
It is likely that patients who seek traditional therapies may indeed gain some true benefit from these time-tested remedies, or some "placebo" beneficial effect, or the delay in seeking other therapies may, in itself, lead to spontaneous remission prior to hospitalization. It is well known that some psychiatric disorders, especially manic depressive illness, may spontaneously remit within a few months of onset. Prior to comparison of hospital admission rates, important variables such as therapy-seeking behaviour before hospitalization of immigrants must be taken into account.

In conclusion, it can be said that immigrant patients continue to seek traditional therapies, which seem to be an integral part of their cultural background. As these therapies have not been scientifically tested, it is difficult to comment upon their efficacy. But there is established evidence that some of them may cause harm because of the ingredients they contain. They may also cause further harm by delaying the patient from receiving more effective care.

However, traditional therapies should not be dismissed as totally ineffective, or as quackery. Some aspects of Western medicine itself may not be acceptable to immigrants. Besides Western medicine does not always have answers for all medical problems. As immigrants find that traditional therapies are more in keeping with their beliefs, systems, and values, they may be more psychologically enhancing.

It would be erroneous to calculate the prevalence of mental illnesses among ethnic minorities based on hospital admissions as the patterns of admissions differ. Thus, figures that suggest that mental illnesses may be four times as common among immigrants when compared with host nations, should be viewed with care. When planning for services for communities where there may be a substantial amount of immigrant population, the needs of these individuals must be borne in mind.

THE SPIRITUAL APPROACH



Hindu-Buddhist Therapies

by A.N. Singh

The Hindu Medical System evolved about 1500 B.C. when the *Veda* of long life or *Ayurveda* was written. Without a doubt, Hindu medicine developed independently, and Javaka, a physician, originated, combined, articulated and homogenized the Hindu and Buddhist approaches into one. It is worthy to note that Javaka was the personal physician of Lord Buddha and travelled far and wide under many names. In Egypt he treated the Royal Family and in Thailand, he established the science of medicine. Lord Buddha was greatly influenced by Javaka. Perhaps the tradition of having a good knowledge of medicine and hygiene in Buddhist monks started from then on.

Buddhism, after the death of Lord Buddha in 544 B.C. and with the conversion of Ashoka the Great, became the "state religion". The combined medicine of Hindu-Buddhist teaching reached its golden age during the regime of Ashoka and for the first time in India, hospitals for the treatment of human diseases were established throughout his empire. Buddhist monks usually carried with them the handbooks of medicine, pharmacopœa and nursing. These monks then planted this science of medicine in South East Asia.

Hindu-Buddhist medicine bases its psychological theories on a combination of theology and philosophy of life and human life. In all its forms, it flows as a series of links in a long chain of natural functions, thus explaining the concept of psychological abnormalities. The phenomenon of spiritual migration covers the various states of life which fluctuate from "ecstasy to stuporous conditions" causing loss of living partnership between body and soul. The capacity to control and the desire to achieve calmness by spiritual means is considered essential for attaining *Nirvana*.

The Hindu-Buddhist approaches impart information and knowledge concerning the measurable structure and powers of the psyche. The Hindu view clarifies the processes by which experiences are apprehended, assimilated, interpreted and comprehended. The Buddhist approach eradicates the cause of sickly spells, dreams of ignorance, and makes it possible to attain serene awakened perfection.

Together, the two approaches help us to assimilate the foundation of our being, without which everything remains stressful and empty. Psychosomatic diseases are pathological expressions of biological, psychic and social parameters of health and illness, whereas the Hindu-Buddhist approaches show a way to bind closely the normal inter-relationship of the former.

The essence of the Buddhist approach lies in the power of producing "Mind made bodies". The doctrine of *Karma* is another vital aspect of Buddhism. According to this doctrine, the whole phenomenal universe is perceived to be an effect corresponding to previous thoughts, speech, and physical action of all living beings. The three forms of *Karma*, action of body, speech, and thought, can be embraced under the power of "Mind made bodies".

Lord Buddha reminded us of four holy truths *(Shitai)*; namely, Truth of Sorrow *(Ku)*, Cause of Sorrow *(Ju)*, Extinction of Sorrow *(Metsu)*, and the Way to the Extinction of Sorrow*(Dou)*. Thus the master simply wished us to set in order body and mind by *Karma* formations. The eight-fold parts of life therefore according to Lord Buddha include 1) right intentions, 2) right speech, 3) right effort, 4) right concentration, 5) right mindfulness, 6) right conduct, 7) right views, and 8) right livelihood.

The combination of Hindu and Buddhist approaches thus brings out the continuity of body, soul, and mind. They lead us to absoluteness,

attainment, and *Nirvana* by the knowledge of four holy truths and by the route of eight-fold holy paths of life.

The success of these approaches in psychosomatic disorders has produced many admirable proven and successful therapies.

YOGA. The *yoga* system traditionally belongs to six-system or *sad-darsanas* of ancient Hindu philosophy. Compiled comprehensively by Patanjali, the system of *yoga* forms a bridge between the philosophy of ancient India and the fully developed Buddhism in the transcendental dimension of spiritual consciousness. The yogic approaches thus are inner urges of self evolution. They can act as a vehicle for successfully controlling the pathological expression of biological psychic and social parameters of illness.

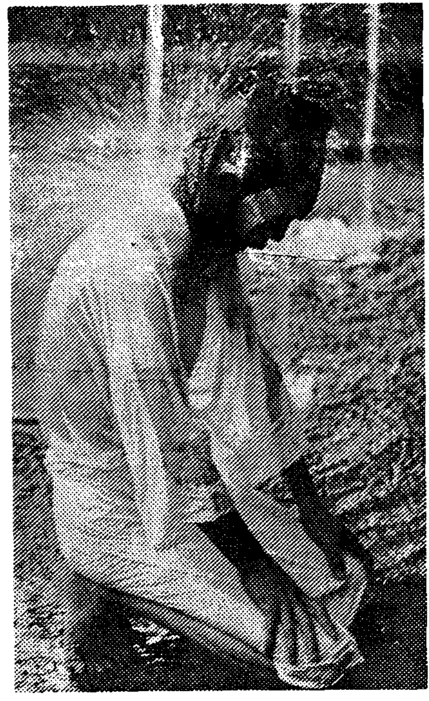
Breathing exercises help in bioenergy control which then stabilizes emotional upheaval of illness. *Yoga Asanas* manipulate the nervous system and divert body energy to establish the equilibrium of physical, mental, and spiritual aspect of individual's life. *Yoga* hygiene not only removes the habit of unhealthy nutrition but also establishes homeostatic balance.

Recent work by scientists indicates that *yogic* approaches can be successfully used in the management of: a) essential hypertension, b) migraine, c) peptic ulcer, d) chronic sinusitis, e) intractable pain, f) anxiety reaction, g) anxious depression reaction, h) gastritis, i) mucous colitis, j) cervical spondylosis, k) bronchial asthma, l) rheumatism, m) headache, and n) personality disorders.

Yogic therapies are based on self regulation and self regulation of the patient whereas pharmacotherapy or most of the psychotherapies foster dependence either on a physician or a drug.

Thus pharmacotherapy or psychotherapy should not accompany the yogic therapies. Tranquilizers or antidepressants reduce

Zen therapy has had significant success with psychosomatic disorders



the proprioceptive stimulation and feedback, thereby decreasing somatic and psychic awareness. Besides, pharmacotherapy not only disturbs homeostatic rebalancing, but also decreases motivation and self insight.

ZEN THERAPY. The word *zen* comes from sanskrit word *Dhyana* as well as from the Chinese word *Chan*. The simple meaning of all three words is "Meditation".

Lord Buddha preached that meditation not only widens the range of our spiritual awareness but also adds one or more dimensions to our actual existence by awakening our psychic and supernatural gifts. From India, Bodhidarma introduced the *Zen* School in China, 1500 years ago, and through the Chinese route, it arrived in Japan via Korea and was confined among the Buddhist religious people. Japanese Zen is divided into two main sects:

Rinzai. Here the importance is given to wrestle with *Koans*. The prime function of *Koans* is to serve as the medium through which the understanding can be reached to attain spiritual enlightenment or *satori*.

Soto Zen. According to this sect, "The Buddha nature is ever present, not something to be attained or wanted, but only to be realized". Remember the emphasis on "only to be realized" not "to await enlightenment". *Zen* therapy came into the armamentarium of therapies in 1948 and since then many research activities have taken place to confirm its significant success in psychosomatic disorders. The indications of this therapy has been in neurosis, personality disorders, tension stages, peptic ulcer, irritable colon, and temper dyscontrol.

The Sixth Patriarch of Buddhism defined word *Za* as outwardly to be in the world of good and evil, yet with no thought arising in the heart. While *Zen* means inwardly to see one's own nature and not to move from it and this is meditation with "self observation". The process of *Zen* therapy involves: a) tension releasing stability of body and mind which progresses to b) the stage of integration of body and mind, c) the stage of concentration, and finally d) the stage of meditation.

To quote Bodhidharma "O Monk when you each believe that you yourself are the Buddha, your mind is no other than Buddhamind." Thus the meditation brings the next stage of enlightenment or *satori*.

Satori is thus seeing oneseslf as Lord Buddha where all phenomena of the world are united and realization of a supreme peace of mind is attained. Fear, doubt, and sorrow disappear and one feels himself the true part of Lord Buddha. For the therapy of psychosomatic disorder, this attainment of peace can give any patient the feeling of self-realization, self-confidence, and self-achievement. This will lead him to a healthy spiritual condition.

Monko Therapy: Like Hinduism, Buddhist religion has propagated the value of incenses in worship, in meditation and in home. In India and from the 7th century onward in Japan, incenses have been considered as a source of increasing purification around the environment and in these cases used as medicine. This therapy caught my

eyes because in Bihar, India, Hindu priests use a similar incense ritual to produce relaxed atmospheres during religious ceremonies.

Morita Therapy: This therapy was developed by Dr. Seima Morita. It has its root in Zen Buddhism. The main indication of this psychotherapy is in patients with *Shinkeishitsu* (obsessive compulsive disorders) or in a term of hypochondriacs. The characteristics of *Shinkeishitsu* are: a) absolute bed rest, b) light work period, c) heavy work period, d) life training period. A direct approach to stimulate constructive forces within the patient is preferred over the obstructive and pathological conflicts of his personality.

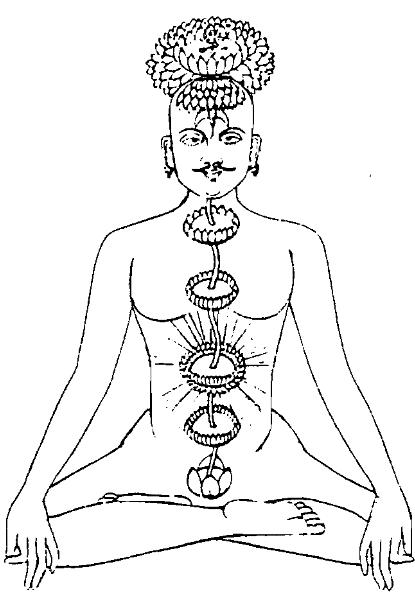
The absolute rest period makes the patient ready to face his own problems which he does by means of a diary. Emphasis first is given on creative effects of nature, which leads into the attitude of acceptance.

Mo-he-zhi-guan Therapy: This therapy originates from the same name of the *Mahayana* book written by the famous Chinese monk of the sixth century, Chih-I. According to Mo-he-zhi-guan, "Primary ways" are the rules of Buddhism. The primary ways include five rules. The first rule consists of arrangement of clothes, food, and companions. The second rule is a very vital one – needs. Suppression of five diseases arising from the five sense organs. The third is discarding the five obstacles of the mind; like greed, anger, laziness, ignorance, and doubt. The last rule is adherence to five *Dharmas*, namely wisdom, concentration of mind, active will, conviction, and patient effort.

The nucleus of this therapy lies in a) removal of cause if known, b) drug therapy, c) meditation, and d) willingness to change. The actual processes involved in therapy are: 1) breath control, 2) suggestive therapy, 3) insight reality therapy, and 4) concentration of mind. This therapy can be used not only in treatment, but also in prevention of psychosomatic disorders.

Common syndromes benefited

Yoga has been successfully used to manage a host of medical and psychological ailments



by this therapy include anxiety, neurosis, peptic ulcer, irritable colon, chronic gastritis. This therapy reminds us that state of mind and way of life are responsible for either disease or cure of disease and total realization of cause always helps.

Kenpo Therapy: This very old art which originated in India 6000 years ago helps in unification of consciousness, increases the cerebral circulation and concentration, thus providing human beings with the capacity for healthy mental activities. The healthy mental activities are important for self control as well as self confidence. In India, the *Kenpo* therapy was utilized in olden days by Buddhist monks for defending themselves from attacks. At the time of Shakyamuni, this art already was a part of defensive or martial art. Bhodhidharma, the originator of the Chinese *Zen* school took this art to China. *Kenpo* disappeared from China but was carried to Japan, and now there are two schools which teach it.

Naikan Therapy: Naikan Therapy was discovered 36 years ago by Mr. Ishin Yoshimoto, a Buddhist. exercises of a Buddhist sect and consists of "self reflection". Two stages are in use for this therapy: a) the first stage includes a marathon session lasting 12 to 15 hours for 7 days, and this stage moves into the second stage of b) subsequent application of therapy for 1 to 3 hours every day.

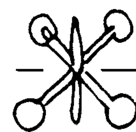
Hindu medicine and Buddhist medicine are not only very closely connected, but Hinduism was in the first place the system in the midst of which Buddhism originated. One can say Hinduism is the mother of Buddhism. Buddhism took from Hinduism the belief in rebirth, *Karma* cosmological theories, but the system of salvation remained different.

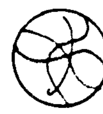
In the same way, Buddhist medicine has its origin in Ayurveda. Essentials of *Yoga* were accepted, though more were added and a few were modified. *Zen* therapy is booming in Japan as well as *Morita* and many other therapies described, but they are a product of the perfect symbiosis of Hindu and Buddhist beliefs, approaches, and philosophy.

Modern medicine relies heavily on curative medicine, less so on preventive medicine. But always the basis remains materialism. In comparison, Hindu-Buddhist approaches stress the preventive, curative aspect equally by the total control of human mind and body through spiritualism. There the path of enlightenment or *satori* attracts people by giving them a chance to live more positively with stronger mind and body to overcome illnesses.

Western psychiatry's psychotherapy focuses on rationalizintg the superficial causes of psychosomatic disorders and hopes the development of insight will occur in the patient, which will eventually result in control or cure of the disease concerned. In contrast, Hindu-Buddhist approaches have produced dynamic psychotherapies which do not live alone in speeches, but in actions of body, soul, and mind. ▲

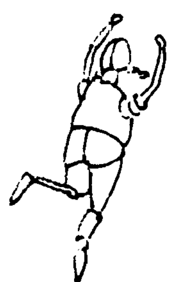
POETRY

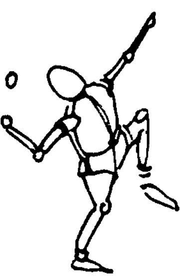


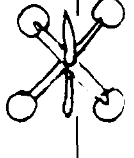


AN EARFUL OF ADVICE

Juan lent me his hand
Opened a mouthful of concerns
Hard as that to believe
I am in the place
To sympathize instead
He had the least idea
of motherlove
Spending most of his life
To dream of chasing after
A bunchful of "kids"
That dashed stones at her
On the purpose of degrading
His mother who doesn't know English
Opening her eyes to loneliness
She spoke with
The friend within herself
Ended up in institutions
For reasons unknown
Mother becomes a word
Lost in Juan's vocabulary
Motherlove
Indeed, is a luxury to Juan
But, what did
He not deserve?



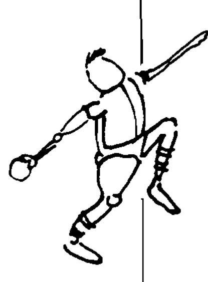


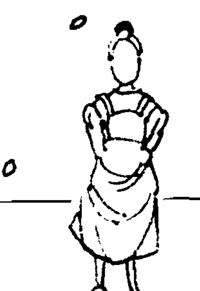


MY LAST ARROW

From a blunt angle.
With my lonely bow,
I shot my last arow
At the only angel.
She startled!
Turning into a sparrow.
Will the same love show?
Was I in love with her soul?
If she was not "physical".

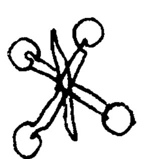
by Cecil Lam





by Michelle T.

CAPTURED IN MIND AND HEART



Elated by a dream,
ruined by reality,
surrounded by chaos,
running from eternity.
Heart ceases to open,
when logic presents its case,
which one will win,
in this forever exhausting chase.
Captured in mind and heart,
victory in a dream,
promises in reality,
may just find a peaceful stream.

A LIFE SENTENCE

Did our time, in grey, cold cells,
freedom and the punishment begins,
will you ever forgive us,
for our unforgivable sins.

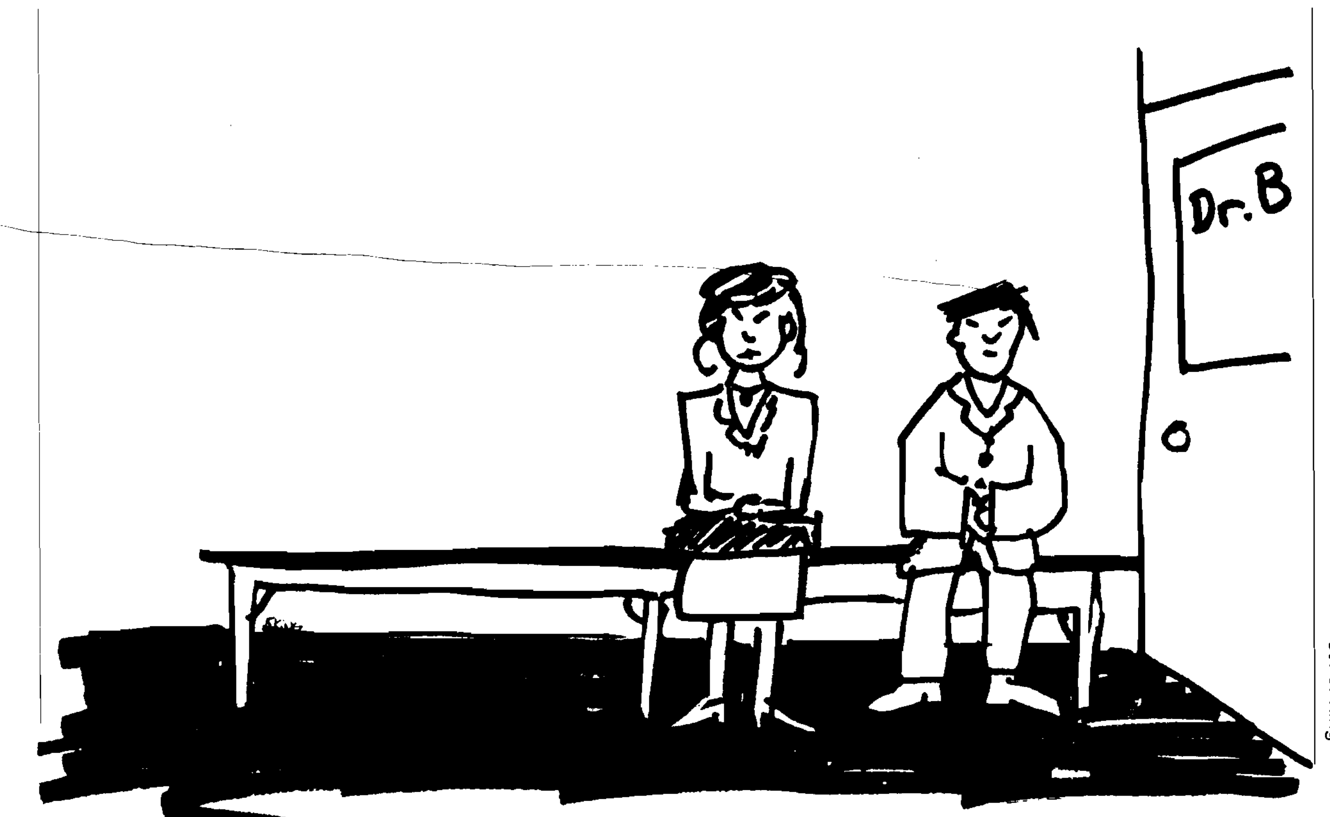
We lived in horror
gazing over our shoulder,
sometimes for a minute,
even for an hour.

One dim, aggraving light,
hollow sounds, of locking gates,
praying for peaceaful death,
as we toss in the endless night.

Must be strong, must be tough,
"Get up", "Move it", "Shut up or else",
hell in some buildings,
don't you think we've paid enough.

My Experiences as a Vietnamese Doctor

by Bach-Tuyet Dang



Sandi King

After high school education in Vietnam, I had the rest of my training in the U.S. and in Canada. So when I started to work with Vietnamese patients I, too, experienced culture shock. I was put back 20 years and was confronted with cultural and mythical beliefs that I had forgotten in the last 13-14 years.

The technological gap between the Southeast Asian peoples and the Canadians is tremendous. Every scientific advance is well applied to medicine in North America. As doctors in Western society, we have "the science belief", which widens the gap between us and our patients. But I show my respect and listen to my patients, instead of putting them down as being backward and uneducated, and try to draw medical meaning from their stories. If they tell me about a ghost living in their bowels causing upsets, I accept this belief. And I go on to solicit other symptoms to help me in formulating my conclusion or diagnosis.

> He claims that he accepts his wife's success, but his gut is bleeding

The other difficulty Southeast Asians have is the psychological problems that come from having lived in war-torn countries, where people are exposed to continuous emergencies. They are psychologically tuned up for responding to emergencies, for short term planning, for quick results. They do not have the benefit of time, of waiting or planning for a few years in advance. Long-term psychotherapy is not feasible. You have to show good results quickly or they don't trust you.

Sometimes I have to explain to them the natural course of the diseases. For example, in cases of the common cold, I tell them that the symptoms will go away in a few days, regardless of what they do. Herbal medicine, or the cold medicine I prescribe may relieve the symptoms, but it makes no difference in the long run. I find it is a very slow process to teach health knowledge. I often have to repeat the information many times. Gradually, by word of mouth, and by personal experience, when they see that what I say is coming true, they gain faith in this new knowledge and transmit it to others in the community.

The family is a very important unit in Southeast Asia and in China. During war, the family, as a unit, is what the individual can depend on, regardless of religious and political

beliefs. The refugees, who were lucky to have come early and are now reunited with their families, have more support. The problem is more pronounced for people who came as individuals. They feel lost in the big cities of North America. When in crisis, they don't know where to turn to.

I find that when I am more in tune with what is available in the community in terms of services, I can refer them to religious bodies, Buddhist or Catholic churches, or to other community services. For example, a young man who lost both parents in Vietnam came to me recently. I asked him what he would have done in Vietnam. He said he would cook some dinner, put on some ceremonial clothes to show mourning and perform some rituals of grieving. I told him to do the same thing here: go to a religious body that is compatible with his faith and would perform similar rituals for him.

I find it a great relief to some of my clients to be able to repeat some rituals that are significant to their emotional health. Furthermore, if they receive encouragement from a Canadian friend or social worker who can view these rituals with a friendly and respectful eye, they would feel more comfortable. Such understanding helps them to relive their tradition as if they have the Canadian permission to assimilate their beautiful heritage into the Canadian society. With that process, I find my patients feel much happier and their sense of self-worth is enhanced. This also helps to reduce the psychotherapy time needed.

The Vietnamese family is still very patriarchal. The men still rule supreme. They have to be listened to. Exposed to the concept of equality between the sexes, the family faces certain conflicts. Coping mechanisms which were effective in Vietnam are no longer appropriate in Canada, especially those involving subordination of women and children. When I first came across this behaviour, I was shocked. Now I tell my clients: such behaviour is no longer appropriate and workable here. There are other ways to cope with the situation. It is a sorting process for them, to decide what old ways are to be discarded, and what new ways are to be learned.

If they tell me about a ghost in their bowels, I accept this belief

Sandi King

With Southeast Asians, I would stress the importance of psychosomatic symptoms as a manifestation of psychological problems. You divide your patient's feelings into three levels: his mind, his heart and his gut. As a family physician, when I am sure there is no underlying physical illness, I sit down and talk to them in colloquial terms: your mind talks this way, your heart talks this way and your gut is telling me something else.

A patient tells me that he is fine, but his heart is palpitating and his gut is bleeding. He has recurrent ulcers which are exacerbated when he learns that his wife is more successful and making more money than he is. He claims that he can accept his wife's success, but on the other hand, his gut is bleeding.

Sometimes I have to divide the patient into three sections, and discuss the different meanings of symptoms expressed by his mind, his heart and his gut. I would also point out that he is not alone. Many people, including Canadians, may react the same way. So there is nothing shameful about it, there is no need to bury it.

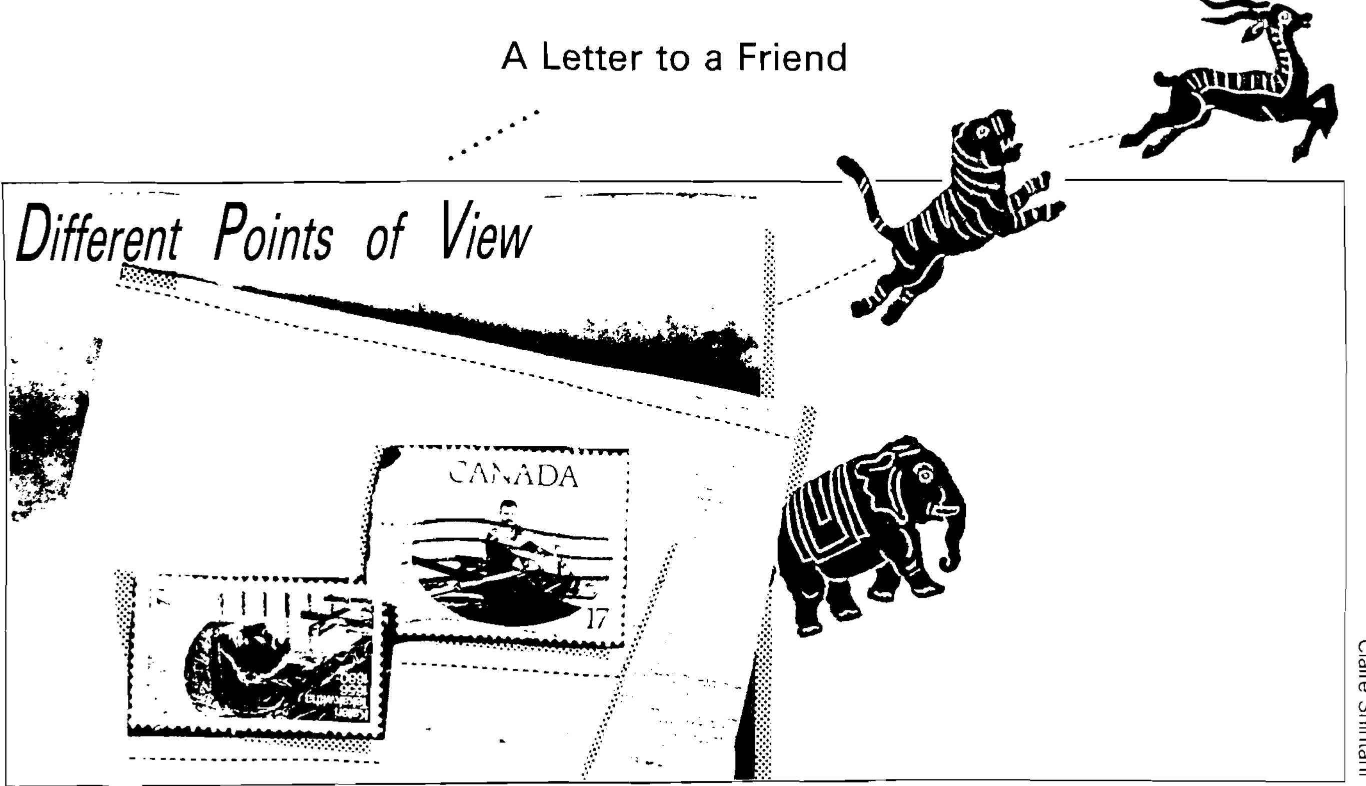
I suggest that to make a proper diagnosis, you need a heightened awareness, to know when a patient is no longer able to cope. When his function in an ordinary life starts to deteriorate to the point that is beyond the situation which will resolve itself, then the patient may be referred to the appropriate agencies for help. For the more difficult diagnoses, one has to refer the patient to a psychiatrist.

In terms of treatment, I have a few recommendations to make. First, reassure the patients that they now live in a peaceful country. There is plenty of time to plan, to study and to be successful. Stress the advantages of long-term planning in a peaceful country. There is plenty of time to resolve family and personal conflicts. People live much longer in Canada when compared to their old countries. There is no need to rush.

I would strongly urge them to participate and contribute to the larger society, to make this their home. The contributions can be their cultural heritage, their own personal strengths and talents. They should be permitted to retain the positive aspects of their heritage, and be proud of it.

A Letter to a Friend

Different Points of View



Claire Shintani

My dear friend,

It was quite interesting and inspiring to read your letter. You always ask intellectually stimulating but difficult questions. This time you asked me to comment upon my perceptions of cultural differences in the concepts and practices of mental health in Asia as compared to North America.

You are well aware that just because I was born and brought up in Asia and have been living in Canada for a number of years does not make me an expert on this subject. Whatever I say will be based on my personal experiences and knowledge and not on any facts and figures or research. These views may also reflect my personal biases and are open to any criticism based on more objective studies.

To talk about health in general, and mental health in particular, is quite difficult without referring to the general life styles of individuals and communities.

One of the first things that I noticed when I arrived in Canada was the emphasis on individuals as compared to the group. Each individual appears to be the primary concern of everybody while the family and the community appear to be secondary. If a conflict of interest arises between an individual and a group, the individual seems to win while the group has to make compromises. This attitude is quite different from the Asian tradition where family and group seem to be of primary importance while individuals seem to sacrifice their needs and interests in the service of community interests.

Tied in with this attitude is the preoccupation of individuals in North America with their rights. A lot of people seem to be talking about their human rights, for example Women's Rights, Patients' Rights, Children's Rights, and very few people seem to talk about their responsibilities seriously. On the other hand Asian tradition seems to emphasize the importance of responsibilities and the virtue of sacrifice. For example, it is still considered a feature of mature and healthy behaviour for young men to discontinue their education or postpone their marriage and work to support their families.

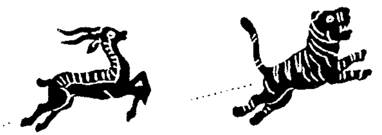
In North America it is not only that everybody is aware of their rights but they also make sure that they get them. If someone does not struggle to get his rights, he is labelled as "passive" and he is advised to get some help to become "assertive."

Assertiveness is becoming a national preoccupation as a sole virtue. (This is reflected in plethora of assertiveness training groups all over the country.) Interestingly, this is considered the most effective way of being successful and happy. If you saw the film *Gandhi* you may have seen a few glimpses of being effective without being "assertive" in a North American way.

The same teenager who is praised for being "assertive" in a Canadian school may be considered rude, disobedient or even delinquent in an Asian school system. Here, on the other hand, an obedient and mature student from Asia may be looked down upon as a passive and unassertive individual.

One other thing that attracted my attention in North America was the emphasis on rational thinking. Reasoning is given great importance and everything that is logical is given a prestigious place. In Asia, faith is considered a great virtue. Reasoning is not only resented at times but even looked down upon as a lower level of thinking. In many spiritual and religious beliefs and practices, the concept of rational explanation is not even entertained.

This attitude may be seen in some religious groups in North America but generally it seems to be far less prevalent. This would reflect that the



society may be far more accepting of a "rational being" in North America as compared to a "believing being" in Asia. While critical and analytical thinking is considered more mature in North America, the traditional thinking, accepting cultural beliefs and practices without question are considered healthier in most of Asia.

This rational mode of thinking and this preoccupation with personal rights seems to be a part of the democratic way in North America as compared to politically and religiously autocratic traditions in Asia (e.g. Iran was ruled by monarchs for 2500 years).

In North America talking about problems is considered a mature practice both in the political realm and mental health field (interestingly psychotherapy is called the "talking cure"). In some extreme cases such a practice of talking to solve problems can go on indefinitely without any definite decisions being reached or concrete results being produced. On the other hand, talking has only a limited value in Asian problem solving practices.

Recourse to the judicial system is widely practiced in North America to solve interpersonal problems and conflicts. Trying to decide on one's own, even with bargains or outright threats and aggressive acts, is more socially acceptable in many parts of Asia.

In Asia the uses of power by someone higher in the hierarchy is more culturally acceptable than in North America. Distribution of power is still more predictable, which is also reflected in the definition of roles. In North America the boundaries of groups are getting looser, allowing each individual to be freer to define his role and negotiate with other members of the groups. In Asia the extended family system is still widely practiced with definite roles for each family member. In North America, changes to nuclear families and even single parent families have created new challenges and unpredictable situations.

Jack

In North America individuals are freer but more isolated

In North America because of

I am not addressing here the question of *Why?* The reasons of all these differences are multiple and complex. One thing that is quite obvious is the changes in socio-economic conditions affecting the life situations. The traditional role of the extended family in Asia is gradually being replaced by social welfare institutions in North America.

In Asia grandchildren are looked after by grandparents and other relatives. In North America children go to day care centres and grandparents to senior citizens' homes. On the other hand young women have far more opportunities to get involved in work and other activities in the community in North America as compared to Asia.

economic independence, individuals are freer to focus on their personal needs, desires, ambitions, and in some cases, even become isolated and alienated. In Asia, however, people still enjoy the emotional support of their closes knit families and friends not only from day-to-day, but also in times of crisis. Many individuals have to stifle their own potential and sacrifice their talents in this process.

The same extent of independence, assertiveness and freedom considered healthy in North America may not be taken to that kindly in Asia. But on the other hand being more compliant, following the group's values and sacrificing personal desires may be considered as a reflection of maturity.

Considering the length of the letter I mentioned only a few issues. There are a number of other values of day-to-day living which are conceptualized and practiced quite differently in different societies.

I am aware that I have made over-generalizations and exaggerations but that was to highlignt some points.

I would imagine that when members of one culture try to be aware of attitudes and practices of another culture mutual understanding is enhanced. Such understanding prevents people from making premature judgements and helps them to adjust to different cultures. It also helps people re-evaluate their concepts of mental health and illness.

In this letter I wanted to give you my views on the subject of cultural differences and mental health concepts. I look forward to your comments and criticisms.

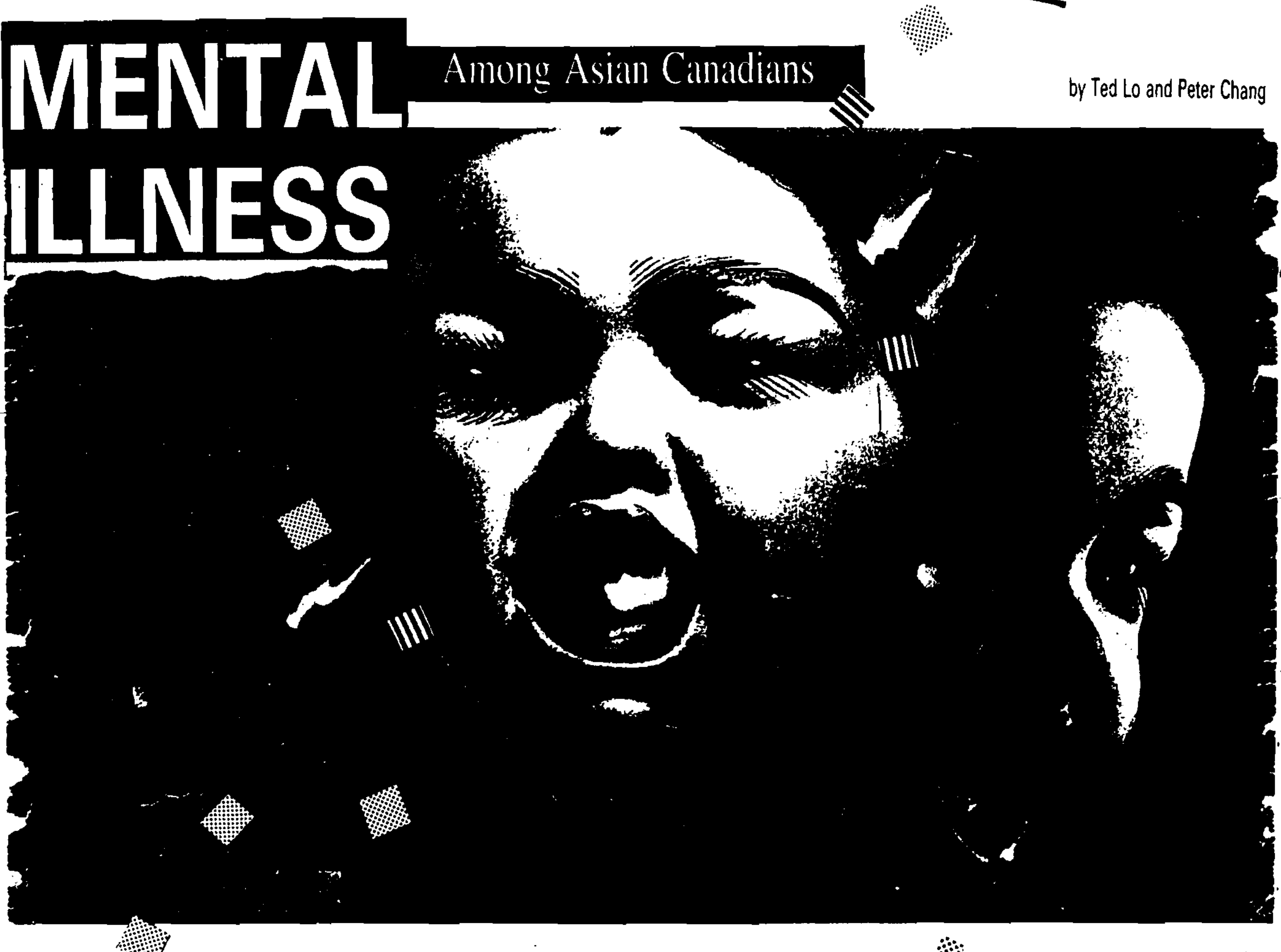
Yours sincerely,

M.K. Sohail

MENTAL ILLNESS

Among Asian Canadians

by Ted Lo and Peter Chang



A great many people know a great deal about mental illness and mental health. Unfortunately, a great deal of what they know is not true.

Dr. J.D. Griffin, 1953.

"Mental illness is a myth! declares Dr. Thomas Szasz, a New York psychiatrist who has been immortalized by these words. According to him, mental illness does not exist. Yet according to a well-known criminal lawyer in the United States: "There is no such thing as a guilty client. He is either innocent, or sick." These illustrate the two opposite ends of a wide spectrum of public opinion in Western society in regards to the concept of mental illness.

The perception and conceptualization of mental illness vary in different cultures, which also exert an influence on the help-seeking behaviour of the identified patients and their families. The interface of two or more cultures also generates certain patterns of usage and potential abuses of the service delivery systems.

A Chinese man was in mental institutions for 31 years — *wrongfully*

As an illustration, let us examine the case of Mrs. Wong, a 35-year old woman of Chinese extraction, who lived in a suburb of Toronto, and had developed a hard sensation at her chest. She consulted many doctors including specialists, but to no avail. There were no other symptoms reported. But when her story unfolded, it became evident that she had suffered many losses in her life, some of these were associated with her recent immigration and her resulting social isolation. Actually her eyes were glistening with tears at the interview, even though she did not acknowledge a feeling of depression.

Mrs. Wong very poignantly demonstrated the phenomenon of "somatization". Western psychiatrists find it very resistant to the usual psychotherapies as the patient defines his or her problem in physical terms. The tendency to do this is not confined to the Asians; indeed it is seen in many different cultures over the world. One might argue that the "psychologization" in the

West is actually a less common mode of comunication between doctor and patient.

Traditional Chinese medicine does not distinguish mind from body. Health is seen as the ideal state of balance, of homeostasis as it were, among the various forces that flow through the human body. Therefore it makes perfect sense for Chinese patients to express their psychological distress in physical language.

Immigration can be a very stressful experience. It involves many changes that require adjustments in a very short time. By definition, it is a crisis. The immigrant has to go through a grieving process for what he or she has left behind in the old country, and simultaneously has to absorb a great deal of new information about the new country. Some immigrants have to learn a new language, find a new job, or receive further training. It is truly amazing that not more immigrants decompensate. Yet in a survey done by Hong Fook Mental Health Association, Chinese patients occupy less than 1% of the psychiatric beds in Toronto, while they constitute 5% of the population.

We believe this represents an underutilization of services rather than a lower prevalence of mental illness in the Chinese immigrants. They often turn to remedies other than psychiatry: herbs, traditional therapies (e.g. acupuncture), religion and solace from family members. Apart from the usual reasons offered for the underutilization of services, – lack of language skills and the stigma of psychiatry – access to appropriate health care is also hampered by the lack of sensitivity on the part of care-givers to the needs of the immigrants.

Recently, a Chinese man was awarded $205,000 by a Chicago Court for being wrongfully detained in various mental institutions in the past 31 years. He was mistaken as being mentally ill as no one could communicate in his language. In Toronto, about two years ago, an Arabic woman died in a psychiatric

Sandi King

Her eyes were glistening with tears but she didn't know she was depressed

ward from an acute abdominal condition. Her wailing was considered a behaviour problem, as no one could understand Arabic.

These two cases illustrate the need for us to learn how to diagnose, or not to diagnose, mental illness in people from different cultures.

Western psychiatrists often try to understand other cultures by referring to the "exotic" syndromes such as *koro, lata, amok, piblokto,* etc. Subsequent research, such as the work done by the late Dr. P.M. Yap, has served to demystify these syndromes by finding satisfactory explanations for the unusual manifestations of illness. From the Asian psychiatrists' point of view, some Western syndromes such as anorexia nervosa and the borderline personality are no less "exotic".

We must not be misled by the apparent differences in the symptomatology of psychiatric disorder in different cultures, as there is solid evidence to support the concept of universality of mental illness. The romantic notion that mental illness is a sequel of civilization, therefore does not exist among primitives, simply does not survive scrutiny. Major illnesses such as schizophrenia and affective disorders are found in every corner of the world.

There are obviously some fundamental principles that are cross-cultural. All human beings are not only biologically similar, but also share many common psychological and emotional experiences. However, they may express emotions in their own idiosyncratic ways. Or, as Professor Vivian Rakoff has put it, "They just package them differently."

We have the unique opportunity in Canada, in our multicultural mosaic, to study the myriad ways that culture can influence mental illness, especially in its expression and in its treatment. The patient, the family and the society all react to the illness differently, sometimes to the patient's benefit, sometimes not. The challenge to all of us is to meet the needs of the mentally ill, regardless of race, creed or culture, in a way that is acceptable to the patient and his family. ▲

THE HEALERS 4 PROFILES

Carmelina Barwick

Carmelina Barwick, who immigrated from the Philippines nineteen years ago, is the Senior Mental Health Consultant for the Social and Community Section at the Clarke Institute of Psychiatry, Toronto. She is also a lecturer at the Department of Psychiatry, Faculty of Medicine at the University of Toronto.

Carmelina embarked on a challenging career after acquiring her Bachelor of Science in Nursing. Her career in Toronto began at the Queen Street Mental Health Centre where she worked as a staff nurse for two years, then as Clinical Instructor for one year. In 1969, Carmelina began her affiliation with the Clarke Institute of Psychiatry. After two years as staff nurse, she became the Head Nurse of the Community Psychiatry Section. In 1974, she changed her role to that of Community Worker. In 1978, she acquired her present position.

Carmelina Barwick's contributions to the field of Mental Health lie in her accomplishments in the community. Her enthusiasm and energy in this area are reflected in her numerous projects. She has made presentations to the Ontario Psychiatric Association, to the American Orthopsychiatric Conference, to nursing conferences for Baffin Island, Frobisher Bay. She is on the Allocation Panel of the United Way of Metropolitan Toronto.

Her concern for human issues and the needs of the mentally ill in the community is seen throughout her career. She has written articles, such as *Survivors of Suicide*, *Help for Families of Suicide*. She has helped to set up Transition House Inc., a residence for psychiatric patients. She was a former member of the Board of Directors of Victor Home for Unwed Mothers in Toronto; she participated in the team which produced the report entitled *Southern Alberta: a Study of Psychiatric Needs and Provisions.*

In the past two years, Carmelina has worked diligently with a group of Chinese professionals to obtain a grant from the Ministry of Health which led to the conception of the Hong Fook Mental Health Association. She is presently a member of its Board of Directors and of the group in evaluation of the services.

Siu Wa Tang

Dr. Siu Wa Tang was born in Canton, China. He is a graduate of the University of Hong Kong. He completed one year of internship at the Queen Elizabeth Hospital in Hong Kong. Doctor Tang, 37, has been in Canada for twelve years.

He started his resident exprience in Psychiatry at Kingston Psychiatric Hospital, Kingston, Ontario. In 1975, he came to Toronto and has been affiliated with the Clarke Institute of Psychiatry and the University of Toronto ever since. He had received Fellowships of the Ontario Mental Health Foundation for three years.

In 1978, Doctor Tang completed his Doctorate in Neurochemistry. In the same year he received the Fellowship of the prestigious Medical Research Council of Canada. He has been a member of the Ontario Mental Health Foundation Scholar since 1979.

Currently Doctor Tang has appointments as Assistant Professor in Psychiatry and in Pharmacology at the University of Toronto. He is presently the Director of the Clinical Psychopharmacology unit at the Clarke Institute of Psychiatry. He supervises research scientists, assistants, technicians and graduate students and collaborates on many projects throughout the Institute and at times, with other hospitals and centres.

His research has involved the use of multiple chemical and biological techniques in both basic and clinical studies. Areas of major research interest range from affective disorders, schizophrenia, aging, organic brain syndrome, to artificial intelligence, molecular biology and psychopharmacology.

Work in the field of research has at times been very controversial leading to misinterpretations of experimentation. Doctor Tang maintains his awareness of such concerns. Among his other memberships, he is a member of both the Human Experimentation Ethic Review Committee and the Animal Experimentation Ethic Review Committee.

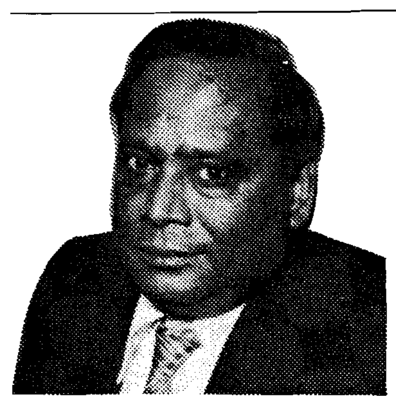
His long list of publications, abstracts and presentations reflects Doctor Tang's devotion to his research. His contributions have been extensive and involve a wide spectrum of activities in the field of Mental Health. His work has been presented at a variety of conferences such as the World Congress of Biological Psychiatry, Barcelona (1978), the International Meeting on Exercise and Hormones, Brussels (1979), the annual meetings of the Society for Neuroscience, the annual meetings of the Canadian Psychiatric Association. Doctor Tang has also been an invited speaker to such conferences as the annual meeting of the Canadian College of Neuropharmacology.

In 1981, Doctor Tang visited China with a group of psychiatrists from the Department of Psychiatry

by Kathy Wong

at the University of Toronto. He presented lectures on the advances in Canadian Pharmacology at the Sichuan Medical College, Chengdu and at the meeting of the University of Toronto and Chinese Medical Society, Guangzhou Branch, Guangzhou.

As psychiatry slowly comes of age, Doctor Tang will continue to make his contribution to mental health in his research.



Amarandra N. Singh

Doctor Amarandra N. Singh, 49, has been Programme Director of Hamilton Psychiatric Hospital, Hamilton, Ontario since 1972. He is Assistant Clinical Professor in the Department of Psychiatry at McMaster University, Hamilton, Ontario. Dr. Singh, a native of India, has qualifications from India, United Kingdom, U.S.A., and Canada. He has had clinical experiences in India, Scotland and England. In Canada, he started at the Regional Psychiatric Centre, Prince Albert, Saskatchewan as Senior Psychiatrist in 1970. He was Medical Director of Northeastern Regional Mental Health Centre, South Porcupine, Ontario prior to his present position.

Dr. Singh has several memberships. He is a member of a committee revising International Classifications of Diseases. He is a member of the International Society of Chemotherapy, the International Council of Prison Medical Services, the International Suicide Prevention Society and the British Mental and Dental Hypnotic Society. He is Secretary of the Programme Committee of World Congress of Prison Medical Services. He is Treasurer of Forensic Psychiatry Section and of Nomenclature and Classification Section of World Psychiatric Association. He has been a British Council Scholar. He was presented to Her [illegible] Queen Elizabeth II as Selected Que[illegible] Scholar of Commonwealth in 1966.

Through his research, Dr. Singh has contributed to the field of mental health. His research exhibits a spectrum of interests. He deals with topics such as depression, epilepsy, prevention of suicide, schizophrenia, obsessive compulsive behaviour, hypnosis and psychosomatic disorders. Dr. Singh is aware of the growing dynamic in the field of mental health. His research into psychopharmacology is innovative.

His endeavours and accomplishments have resulted in an extensive list of publications. He has books on depression in English and French. His articles are found in numerous journals – even in the Hungarian Society of E.E.G. Journal. His papers have been presented at international scientific meetings. He has been Chairman and Moderator in various conferences in countries like Japan, India, Mauritius and U.S.A.

Edgar Wong

Doctor Edgar Wong, 60, born in Ottawa, Ontario, has a very active and busy job as the Psychiatric Advisor at the Department of Public Health for Toronto at City Hall. He is responsible with others, for city-wide projects on mental health and any related issues, such as mental retardation and drug problems of youth. He represents the Health Department on several committees and is on various task forces on mental health concerns.

Doctor Wong has a successful and extensive career in the field of mental health. He studied medicine at Queen's University, Kingston, Ontario. Except for a six year absence while in Philadelphia, U.S.A., for [illegible] his psychiatric [illegible] [illegible] since 1961. He had, for seventeen years, held the post of Director of the Mental Health Division in the Department of Public Health for the city of Toronto prior to his present position.

His experiences involve infants, children, adolescents, adults, seniors, the mentally retarded and physically handicapped as well as the mentally ill. His extensive repertoire also includes community, clinical and legal psychiatry and neurology. As Doctor Wong says, "Experience on the job is ongoing and never ends".

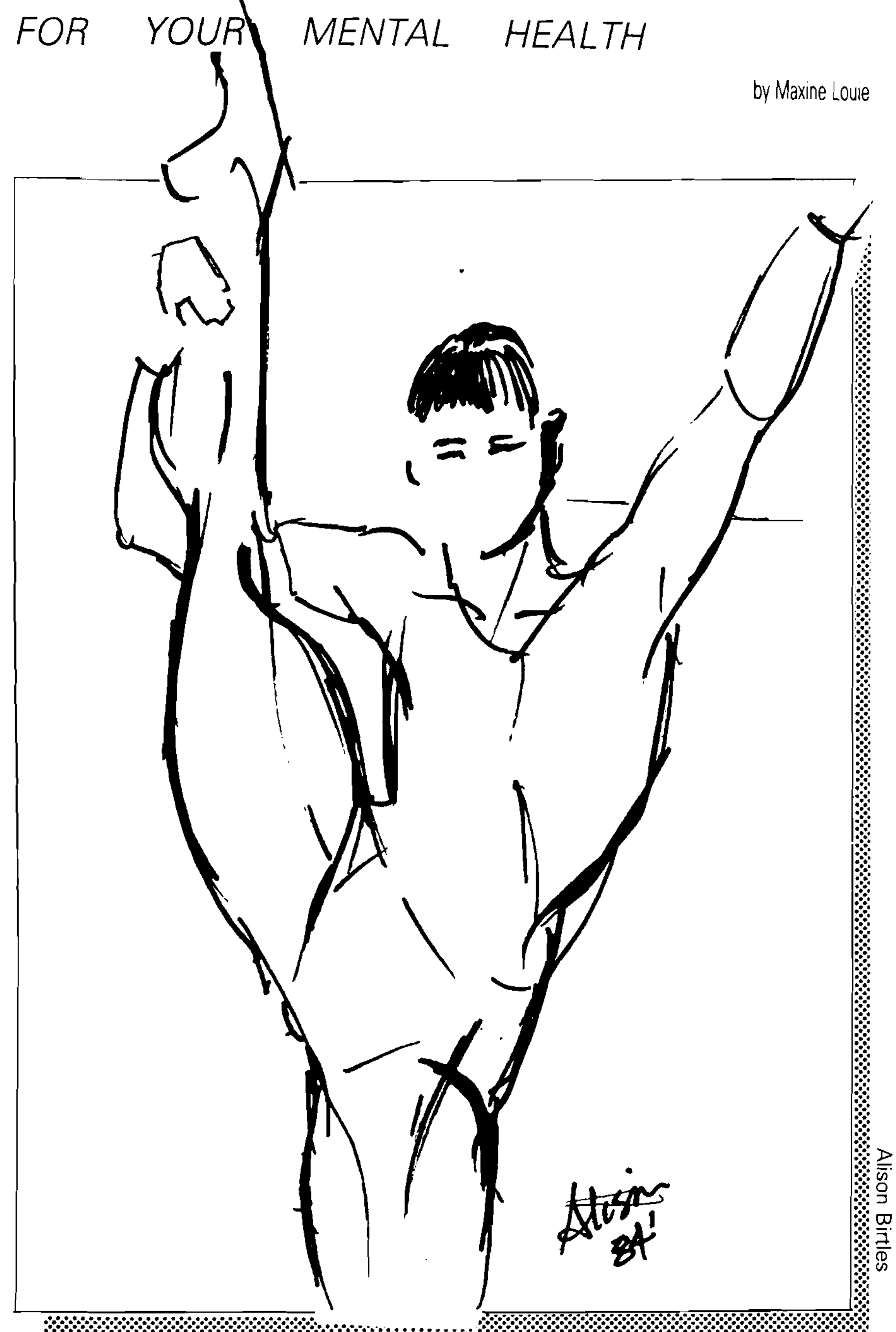
As he maintains his awareness of progressive needs and concerns, Doctor Wong has been involved in special issue programs such as planning of a psychogeriatric assessment service for the Mental Health Division of the Department of Health; housing for psychiatric patients. He has also been involved in committees and committees and discussion groups set up to plan a Mental Health Network for Metropolitan Toronto.

Among his many functions, Doctor Wong is Chairman of the Multicultural Committee, the Disabled Teens Conference and was a member of Staff Advisory Committee on Multiculturalism of the Sesquicentennial Board. Doctor Wong had brought his expertise and knowledge of mental health programs and issues to his former membership on the Advisory Board of the Hong Fook Mental Health Association. His contributions to the field of mental health continues with his numerous projects.

EXERCISE

FOR YOUR MENTAL HEALTH

by Maxine Louie



Alison Birtles

These days you read and hear a lot about the benefits of exercise. However, many people, when asked to exercise, say they get enough exercise in their daily life, i.e. housework, work, shopping, gardening, etc. These are not "exercise" activities, but something you have to do. Exercise has specific goals: flexibility, strength, endurance, and mental fitness.

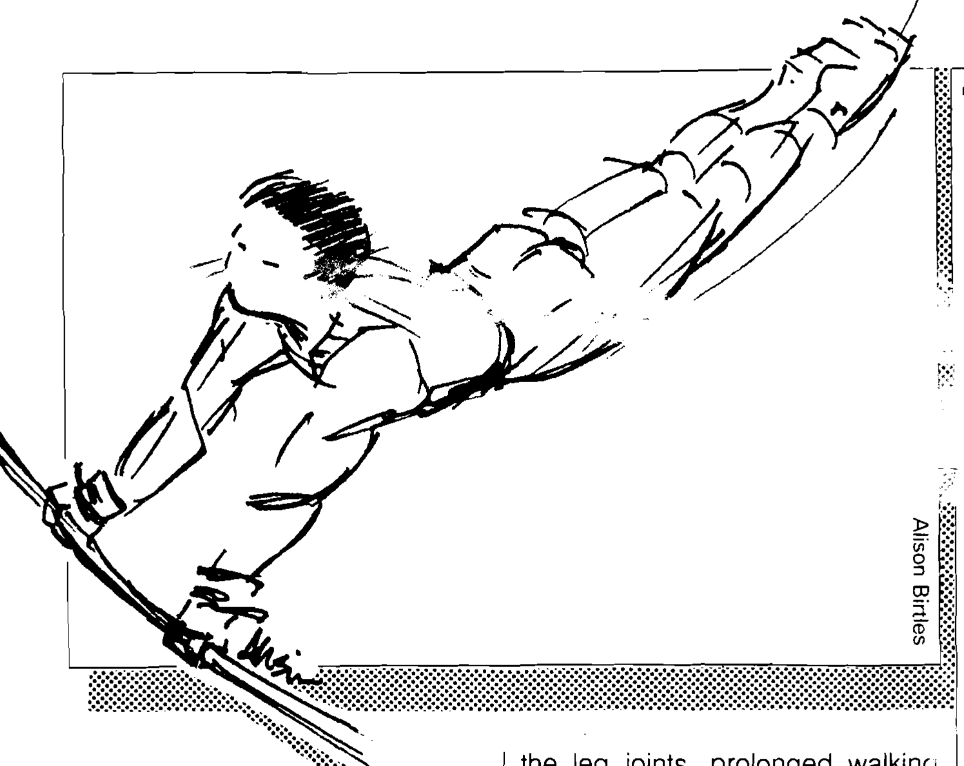
Many Asian immigrants suffer severe culture shock. They should be persuaded to exercise regularly to get out of their imprisoning surroundings, i.e. go for a walk along the Beaches, or up the Don Valley Ravine, etc. Then they will not view their newly adopted country with the eyes of exiles.

Western concepts of exercise are also foreign to Asian immigrants. They may have done some recreational exercises in the old country, but over here they are caught up with the difficult adjustment to their new lifestyle. They must be introduced to the concept of exercise and perhaps be accompanied to the exercise sessions.

If you are thinking of getting into a regular exercise program, but have not been physically active for many years, then it may be advisable to check with your physician first. If you start from zero activity level, start slowly, i.e. with a 5 minute walk, then gradually increase your time to 30 to 45 minutes. Remember, you must do this at least 3 times a week. Every day is even better. Many people make the mistake of starting off too vigorously, feel their muscles become very sore and then never resume. They fear that each time they exercise, they will re-experience that same unpleasant feeling. This won't happen if you start gradually. No need to rush.

Endurance exercises or aerobic exercises (where you exercise for a prolonged time of between 15 and 45 minutes) leaves you slightly breathless and should be performed at least 3 times a week. This is the most beneficial type for the majority of people.

Aerobic exercises include swimming, jogging, cycling, cross-coun-


Alison Birtles

Exercise can give you a "high"

try skiing, golf, dancing and even walking (not window shopping). Done on a regular basis, aerobic exercises are said to encourage the production of endorphins, your body's own morphine, which gives you a "high". Regular exercise makes you feel good about yourself. You are more alert and energetic and feel more able to cope with the many stresses of life.

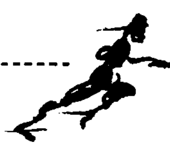
If you are going to jog or run, check with a reputable store that caters to runners for good footwear. Otherwise you could create more health problems (shin splints, torn muscles, etc.). Be sure to ask about good stretching programs to be done before and after jogging.

For those with arthritis involving the leg joints, prolonged walking and jogging may adversely affect your arthritis. Swimming would be the better alternative because water supports your limbs and does not exert great stresses on the sore joints. For those who have heart problems or diabetes, it is best to consult with your doctor for specific guidelines.

Exercise also benefits those who are depressed. The typical image of a depressed person is someone sitting around smoking, watching TV, thinking that he or she is worthless and has no energy to do anything. If that person can be persuaded to exercise regularly, the above benefits will be reaped.

Choose what you like to do; you may as well have fun too. Make a written commitment and keep track of your progress on the fridge door. You shouldn't expect to get immediate results; it takes a while to get into shape. Exercise must become part of your daily routine, just like good food and proper rest. Good luck!

Maxine Louie



CONTRIBUTORS

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Katherine Wong is a psychiatric nurse at Toronto's Clarke Institute of Psychiatry.

Michelle T. and **Cecil Lam** are Asian Canadian psychiatric patients

Alison Birtles

Fatima and Bill's friendship was a nice meeting point of East and West.

Both of them were nearly six years old and grade one pupils. In the first few weeks of the class they were seated separately but since their teacher had put them side by side they were getting along fine.

Fatima's parents were from the province of Punjab in Pakistan while Bill's parents came from the province of Alberta in Canada. Both the families were quite well-to-do and were settled near Toronto.

Fatima was a cute but shy girl, while Bill was quite active and playful. (He was mischievous and enjoyed himself.) He was fond of Fatima and liked her brown skin. In the beginning whenever Bill would tease her, she blushed, but gradually she got used to it and would just laugh back.

Bill's house was at a distance from school while Fatima lived close by. Bill would leave home a few minutes earlier in the morning and find Fatima waiting for him in front of her house. They would say "hello" to greet each other and then walk to school together.

They spent a lot of time together in school. At noon they ate together. Their mothers sent food in their lunch boxes which they shared. At first they found each other's meals different and strange but gradually they not only got used to it, rather, they started enjoying it. Bill enjoyed *chapatis, parathas* and also *ladus, burfi* and *ghulab jaman* while Fatima got used to hot dogs, different types of sandwiches and tuna fish.

Bill was always fascinated with her brown and tanned skin. He asked her if she spent a lot of time in the sun. She smiled and said, "I was born that way." She liked his blonde hair and asked him if he was wearing a wig. He laughed and said, "Yeah! I bought it for five dollars."

After school they walked home together. Since Fatima's home was closer she invited him in. Bill liked her mother as she gave him a lot of treats. He knew that she cared about him. Bill had never met Fatima's father, as he came home in the evening.

Fatima took Bill to her room on a number of occasions. She liked to show him her album and tape recorder. Bill was also quite amused to see her bright costumes. He liked her home dress consisting of *shalwar kamees* and *dopatta*. Once when he praised her clothes in front of her mother, she said, "Bill, my son, I will make some *shalwar kamees* for you as well." Bill was quite excited to hear that and told his mom about that. His mother asked Bill to thank her for being so thoughtful.

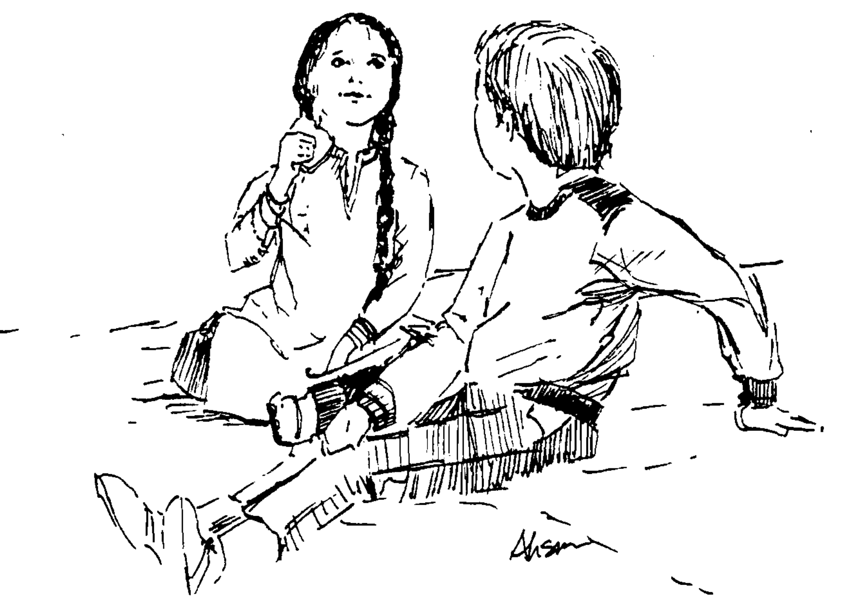
Fatima and Bill were getting closer to each other.

Sometimes when Bill wanted to be mischievous he pulled her braids or ran away with her bag, she ran after him and if she could not catch him, she sulked. Then he would come and try to talk to her. She would turn her face away and stay mad. In such situations he knew how to make her happy. He knew her weakness. He offered her chewing gum and they became friends again.

They were gradually getting frank with each other.

Bill and Fatima used to walk to school side by side. One day he held her hand. She was reluctant but she gave in. Fatima always avoided touching Bill. One afternoon he was very happy. He came running to Fatima, embraced her suddenly and kissed her. She was stunned. Once she regained her senses she was upset.

"Are you mad?" Bill asked.



Alison Birtles

At first they found each other's meals different and strange

"Yes, I am," Fatima replied.

"How come?"

"My mother told me that good girls and boys do not kiss each other." Bill didn't know what to say. He ran away and started playing with the boys again.

One Friday, Bill asked Fatima, "How come you never visited my home?"

"You never invited me."

"Would your mother let you come?"

"I can ask her."

"There is a fair near our house on Sunday. Why don't you come and we can go swinging."

"I will try."

So they promised to meet on Sunday. After they parted that day they were looking forward to Sunday.

Toronto's atmosphere was getting stuffy once again. The feelings of prejudice were being stirred up. Toronto was a strange city. At times everything would be calm and quiet for months and then suddenly a series of unfortunate incidents would occur in a few weeks. It was like rheumatism when joints are painless for months and then, suddenly, when the humidity in the atmosphere increases, they start acting up again.

That Saturday an incident took place which made things worse. Some teenagers who were under the effect of alcohol, were wandering around the corner of Yonge Street, the famous and notorious street of Toronto, making fools of themselves. A stoned Pakistani passed that way, staggering. All those people were probably not fully aware of the fact that alcohol and marijuana temporarily paralyzes that part of the human mind which differentiates human beings from other animal species.

When the Pakistani came close to the local men, he tripped and fell to the ground. All of them burst out laughing. He felt he was being made fun of. In the meanwhile he heard one of them saying, "Oh Paki idiot, be careful." His blood started boiling with anger. He replied, "Oh Monkeys, keep your mouth shut." They started laughing again. Another one said, "You should be ashamed of yoursesIf. Go home." The Pakistani, who was standing again by now, roared, "Who are you to tell me what to do?" The third man pushed the Pakistani while holding him by his shirt. After that there was a free exchange of curses, punches and kicks. The Pakistani broke his jaw while two others broke their noses. Police arrived and a lot of pedestrians

gathered around. The injured were taken to hospital.

A small thing led to a big incident.

Bill's parents were watching television. They heard in the local news, "There was a big fight last night between a Pakistani young man and some Canadians. Both the parties were under the effect of alcohol and street drugs. One Canadian made a racist remark, 'Oh Paki Idiot' which led to a violent fight."

Bill's father was a prejudiced man. He felt very strongly about religious and racial issues. He believed that North American society would be ruined by Jews and Asians. He had a lot of bitterness hidden in his personality which used to come to the surface on such occasions. When he heard the news he said, "These Pakis are mean. They have come here to spoil and ruin our lives." His wife did not like his attitude on these issues. She thought that he always got emotional and overreacted on these occasions. She said, "Both parties were at fault." "No," he said, "Those foreigners try to rule us. We should socially boycott them."

She didn't want the issue to flare up further so she kept silent.

On Sunday after the brunch, Bill told his parents, "This afternoon I am going to the fair."

"Who are you going with?" his dad asked.

"With my friend, Fatima," he replied, smilingly.

"No, you cannot go with her." He was still bitter about the news.

"Why not, Daddy?" Bill was lost.

"She is a Paki and we do not have anything to do with them."

"What is meant by Paki, Dad?"

"Dirty and filthy."

"But Fatima is a very neat and tidy girl."

"And stupid," his father was getting angry.

"But our teacher told us that she was quite intelligent."

"Shut up. Do not give me all these silly arguments. I told you once and for all that you are not going to see her. Do you understand?" He lost his temper.

Alison Birtles

There was a free exchange of curses, punches and kicks

"Okay, Daddy." Bill got scared.

His mom was watching all that; she said, "Fatima is a nice girl."

Bill's father was still shaking with anger. He told his wife, "Now you are trying to take his side. When I said 'no,' it meant 'no.'" He got up and stormed out of the room.

Bill was terrified. His small mind couldn't comprehend what had happened. He had so many questions which remained unanswered. He was confused.

In the afternoon when Fatima came to visit him she was excited but he was dejected. He went to the door and said, "Fatima, I cannot see you."

"Why not?" Fatima was shocked.

"My dad doesn't want me to. He said you are a Paki."

"What does that mean?"

"Dirty and stupid," he repeated his dad. He was so upset that he closed the door.

Fatima was completely lost. She stood outside the door for a while in silence and then went back home weeping. She was hurt.

In the evening when she recovered she asked her father, "Abbu, what does Paki mean?"

Her father was taken aback by this unexpected question. He turned around, scratched his head, swallowed his saliva and said, "Fatima, Paki is derived from the word Pak which means neat and tidy." Fatima noticed her father's uneasiness so she did not pursue the matter and kept silent. She walked away silently. Her innocent mind was full of riddles.

The next day Bill and Fatima went to school separately. They bumped into each other but they looked away. They sat next to each other but did not talk. They were both uneasy and restless but did not know what to do.

As time passed their anxiety increased.

By recess time they could not take it any more. Their patience had come to an end. Their warm feelings of closeness and friendship overwhelmed them.

Bill walked to Fatima very quietly, held her hand and said, "Are you still my friend?" He had tears in his eyes.

"Yes. And you?" She was crying too. Bill offered her gum and she held his other hand.

Bill was sobbing when he said, "I wish my dad could understand our friendship." And they looked at each other affectionately. ▲

COMMUNITY AGENCIES

Serving Asian Canadians

Presented below are community agencies serving the Asian population of Metropolitan Toronto & surrounding areas. This list is but a sample of what is available in the communities. Many of these agencies with multilingual staff act as referral agents & will help to locate further appropriate facilities.

Canadian Mental Health Association (Ontario)
8 Pailton Cres., Toronto M4S 2H8 Tel: 487-5361

Catholic Family Services of Toronto
67 Bond St., 4th Fl., Toronto M5B 1X5 Tel: 362-2481

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Federation of Chinese Canadian Professionals Legal Branch offers a free legal clinic for people every Thursday at 6 p.m. at Cecil Community Centre, 58 Cecil St. Call 598-2022.

Bloor Information and Legal Services can help fill out government forms like OHIP, Unemployment Insurance, Canada Pension and Old Age Security. Counselling and problem solving done. We are a community legal clinic – please call us first at 531-4613.

Citizenship Intergency Project for South-East Asian Newcomers provides Canadian citizenship education classes for people in their native tongue in various locations in the City of Toronto. Call 598-3519 for further information.

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COMMUNITY NEWS

Chinese Head Tax Redress

Large numbers of Chinese were recruited into Canada in the 1800's to help build the railway. They came to *Gum San* (Golden Mountain) with dreams and visions of riches in the new land. But they had no rights and suffered persecution and were exploited as cheap labour. Even though they earned the reputation as hard working honest people, they were dismissed as undesirables after the work on the railway was completed.

In order to limit the influx of Chinese immigration, a Head Tax was legislated. This Head Tax was enforced on no other ethnic group. It was imposed by the Canadian government only on immigrants of Chinese descent, between 1885 to 1923, upon their entry to Canada. It started at fifty dollars in 1885 and was raised to one hundred dollars by 1901.

In 1902, a Royal Commission was set up following the long dispute between industrialists, who wanted Chinese immigrants for cheap labor, and the British Columbia and Alberta governments, which wanted to keep non-voting Chinese out. The Commission found the Chinese immigrants were "a menace and not really fit for Canadian society". This resulted in an increase of the Head Tax to the incredible amount of five hundred dollars. In 1923, the Head Tax was lifted, to be replaced by the Chinese Immigration Exclusion Act. This Act limited Chinese immigration to those meeting very strict requirements making this Act very effective in its exclusion functions.

The Chinese people petitioned against all odds for rights and equality. They did not hesitate in their struggles against challenges to establish freedom. These events culminated in the repeal of the Chinese Immigration Exclusion Act in 1947. Chinese Canadians were finally given some benefits and rights of Canadian citizens. Many of these people who have lived through these difficult times are still alive and are today bringing forth their Head Tax receipts for redress. These elders must not be abandoned for we, the present generation, owe them so much.

Certain actions have already been taken. The Chinese Canadian National Council has undertaken the concerns and interests of the Head Tax registrants. Forums and rallies have been organized across Canada with nation wide coverage in Chinese and Canadian newspapers. Members of Parliament with a large population of Chinese Canadians in their constituencies have taken interest in the Head Tax issue.

The momentum must not be lost. This generation of Chinese Canadians should be proud to uphold and safeguard the rights, freedoms and equality given to them in their heritage.

Kathy Wong

South Asian Canadians Meet

In an important development, leading and active members of the South Asian-Canadian communities from Vancouver to Halifax met in Toronto on August 10 and 11, 1984. Their purpose was to examine the responses of the major political parties to multiculturalism and issues of particular concern to visible minorities, and to develop strategies to articulate their demands during the final weeks of the recent election campaign.

The delegates to "Equality Now for Canada's South Asians" conference, sponsored by the Ad Hoc South Asian Committee on Equality Now, expressed dissatisfaction that the concerns and expectations of visible minorities, such as South Asians, had not been given an integral place in the platforms of the three major political parties. They unanimously adopted a list of demands which has now been transmitted to the leaders of the Liberal, the Progressive Conservatives and the New Democratic parties.

The demands to the political parties relate, among others, to the areas of discrimination in employment, racism and hate propaganda, human rights, immigration and women's and youth's problems.

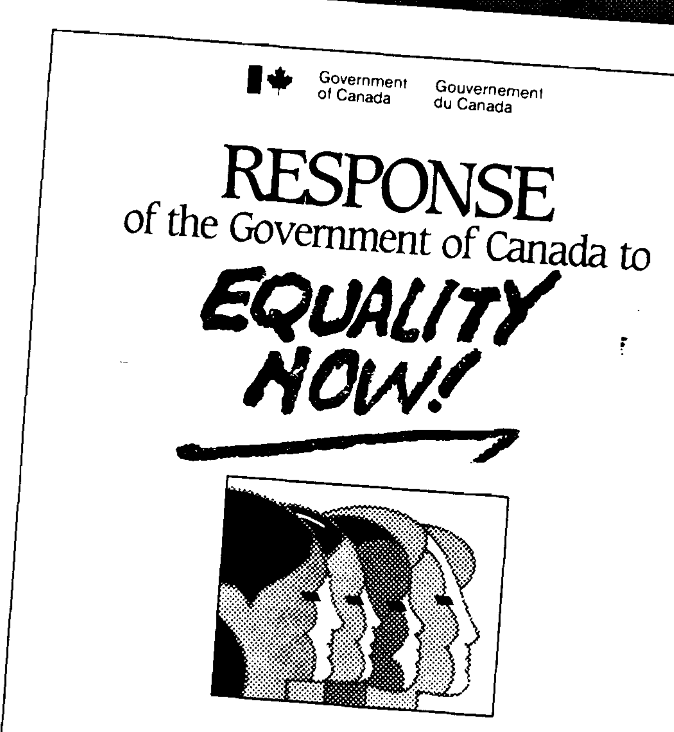
Some of these demands are:

- mandatory affirmative action program for visible minorities in the public sector
- contract compliance policy in the private sector
- removal of the "Notwithstanding" clause from the Charter of Rights and Freedoms
- uniform application of laws and procedures regarding the admission of refugees, and,
- guaranteed programs for the social and economic welfare of visible minority women and youth.

The group also agreed to urge the National Action Committee on the Status of Women to include questions relating to the concerns and problems of visible minority women in the leaders' debate on women's issues on August 15. A list of issues has been forwarded to the national Action Committee for this purpose.

Government of Canada Gouvernement du Canada

The Response of the Government of Canada to "Equality Now!", the report of the Special Parliamentary Committee on Visible Minorities in Canadian Society, is now available.



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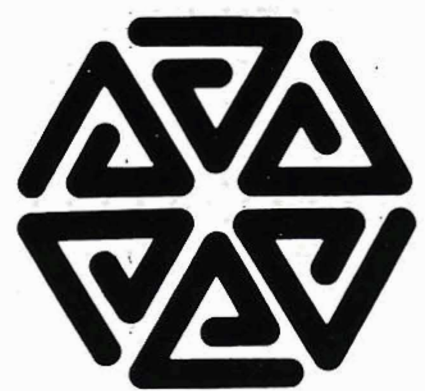

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