DEVELOPMENT OF A CULTURALLY SENSITIVE SCREENING TOOL: POLICY AND RESEARCH IMPLICATIONS[1]

Shahlo Mustafaeva is an international student from Uzbekistan currently pursuing her degree in Clinical Psychology at the University of Regina.

Regan Shercliffe is an Associate Professor of psychology at the Luther College, University of Regina.

ABSTRACT

During the past two decades, Canada has received a large influx of refugees from Asian countries (Noh, Speechley, Kaspar, and Wu, 1992). Upon arrival, refugees are offered health screenings, specifically for communicable diseases, such as tuberculosis, Hepatitis B and for general pre-existing medical problems. Unfortunately, the same attention is rarely given to potential mental health needs. Research has shown that the refugees are at high risk for developing depression compared to non-refugee populations, yet they are not screened. The purpose of this article is to outline the process of developing culturally sensitive depression screenings tools for Karen refugees. The need and implications of this measure are further discussed.

INTRODUCTION

Depression is one of the leading mental health problems facing individuals in all demographic and ethnic groups (Baker and Woods, 2001). The symptoms of depression are psychiatric (e.g., anxiety/nervousness and reduced concentration), behavioural (e.g., social withdrawal and crying spells), and physical (e.g., pain, headaches, and insomnia). Over time, many of the symptoms of depression can become debilitating in nature and impact both the patient's medical treatment and workplace productivity (Greenberg et al., 2003). Psychiatric and physical impairments associated with depression generate a significant cost burden not only for sufferers, but also for their employers, third-party payers, caregivers, and society in general. Depression is associated with a loss of personal productivity, diminished quality of life, poor psychological adjustment, reduced income, high health care utilization, and a markedly increased risk for suicide (Katon et al., 1986). In 1990, the economic burden of depression in the United States alone was estimated between $43.7 billion and $52.9 billion, based on the cost of depression treatment, lost earnings due to suicides, and workplace absenteeism (Greenberg et al., 1993; 1996). During the past two decades, Canada has received a large influx of refugees from Asian countries (Noh, Speechley, Kaspar, and Wu, 1992). Given this population trend the economic burden of depression may have increased from that of the 1990s as the prevalence rates of depression in refuge population is higher compared to that of non-refugee population (Carlson and Rosser-Hogan, 1991). The purpose of this article is to outline the development of a culturally sensitive screening tool and it proposes that this culturally sensitive screening tool can be developed and used in understudied, culturally distinct refugee populations, and that such use will help health care professionals in identifying depression in immigrant populations.

DEPRESSION AS A GLOBAL PROBLEM

Epidemiological studies have identified depression as the most prevalent disorder in refugee populations and one of the ten leading causes of disability worldwide (Steel, Silove, Phan, and Bauman, 2002; Mollica et al., 2004). The process of displacement has a tremendous impact on the health, social and cultural well-being of refugees, as well as host countries. Upon the arrival of refugees, health care agencies focus their attention on meeting basic needs such as controlling infectious diseases and other health conditions. Although this focus is crucial, the psychological well-being of newly arrived refugees is often neglected. All too often refugees who have come to Canada have experienced or witnessed traumatic events including war, forced displacement, famine, etc (Arcel, 1995; Lipson and Omidian, 1995). In the country of resettlement, refugees continue to face a number of stressors such as financial difficulties, broken extended families, loss of family support, cultural and linguistic isolation, and/or

struggles to learn a new language and culture (Lipson and Omidian, 1997; Hauff and Vaglum, 1995). While many refugees are resilient, these various pre- and post-migration stressors put refugees at high risk of developing depression, as such, accurate screening of depression early in the immigration process is urgently needed for detection and treatment purposes.

CHALLENGES IN PRIMARY HEALTH CARE SETTINGS

Depression is one of the most common mental health problems seen in the general medical setting. Although increasing attention has been paid to depression in the research on the general population; public health efforts in screening for depression in refugee populations still lags behind. Refugees are more likely to seek care from general health practitioners than from mental health providers because it is less stigmatising. In addition, refugees, especially from Asian cultures, present with somatic symptoms (e.g., physical pain, headaches, weakness in the body etc) when expressing depression which puts them at risk of being misdiagnosed or treated with inappropriate medications for extended periods of time. Some health care agencies use readily available depression measures that are derived from Western definitions of depression, and these measures are translated for use with different refugee populations. The use of translated depression measures with refugee groups is an understandable starting point. However, many researchers suggest that the application of existing instruments to the assessment of depression in ethnic minorities may not only misrepresent the illness they suffer from but may also mislead prevention and treatment efforts (e.g., Kim, 2002; Phan, Steel, and Silove, 2004; Miller et al., 2006; Okello and Ekbald, 2006). A strict reliance on the Western understanding of depression risks inappropriately prioritising psychiatric syndromes that are familiar to Western health care professionals, but may lack meaning to non-Western populations for whom local expressions and idioms of distress are more salient (Miller et al., 2006).

Although depression-screening instruments have been validated and extensively studied in Western countries and various translating methodologies have been employed to enhance the linguistic equivalence of measures, their translation and use with other cultures is not nearly as simple as it might appear (Ahmad, Kernohan, and Baker, 1989; Bravo, Canino, Rubio-Stipec, and Woodbury-Farina, 1991; Bravo, Woodbury-Farina, Canino, and Rubio-Stipec, 1993). Symptom terms often sound awkward or incomprehensible when translated, even if the wording is semantically correct (Yeung et al., 2002). Although terms that address biologically-based symptoms (e.g., fatigue, insomnia, appetite) can be more easily translated and understood across cultures, subjective psychological aspects of depression (e.g., feeling sad, feeling blue, depressed) are much more influenced by culture and language and vary across cultures (Ghubash, Daradkeh, Naseri, Bloushi, and Daheri, 2000). Thus, the application of these instruments to people whose culture differs from the population on which they were initially developed and validated could lead to erroneous conclusions and misdiagnosis (Kazarian and Evans, 1998). Culturally sensitive approaches in screening refugees play an essential role in planning services and prevention strategies. Depression is a universal mental health phenomenon that is amenable to treatment once diagnosed (Westermeyer, 1991; Weissman et al., 1996). If undetected and untreated, however, depression can become a debilitating problem for any person of any age and ethnic group.

DEVELOPING A CULTURALLY SENSITIVE SCREENING TOOL

Cultural sensitivity in assessing mental health problems and the development of effective psychological interventions requires an understanding of the ways in which people in particular cultures articulate the ways they have been affected by adverse life events (Rogler, 1999; Summerfield, 1999). Familiarity with culturally specific idioms or expressions of distress allows health care practitioners to communicate effectively with distressed community members and to develop mental health interventions that are likely to be perceived as responsive to local beliefs and values (Summerfield, 1999). Culture affects aspects of the illness such as the way symptoms are described and it also affects the experience of illness. Thus, symptoms associated with depression may vary from culture to culture and some symptoms may be more prevalent in one culture than in another (Levek 1991; Suleiman, Bhugra, and Silva, 2001). Therefore, for accurate diagnosis and treatment, health care professionals should first identify and attempt to understand cultural expressions, symptoms, and understandings of depression.

NEEDS ASSESSMENT

The Regina Community Clinic, who screens all refugees in Regina, has indicated that symptoms of depression among Karen refugee groups are high, however, accurate diagnosis is difficult. The physicians report that Karen refugees often present with many somatic complaints such as headaches, body aches, weakness in the body, heart problem or "heart disease"; but the medical tests administered fail to find any physical pathology. The misdiagnoses and related treatments of the somatic symptoms then generate considerable health care expenditures in terms of clinic

visits, laboratory testing, medication prescribing, test ordering, and other medical costs, and result in preventing the initiation of timely and appropriate treatment for depression. The reality is that there is still a paucity of culturally appropriate screening tools that can help health care professionals screen for depressed and non-depressed refugees, and this is most certainly the case for Karen refugees. Moreover, there are no data available indicating the extent to which symptoms of depression are present in this particular population nor has a system been developed to allow systematic screening/monitoring of this refugee group. As a result, there are no specific reports of mental health needs among Karen refugees.

Given the absence of culturally sensitive screening tools, the exact rate of depression in this population is unknown. The Karen community is one of the largest refugee groups in Saskatchewan and has been exposed to traumatic events prior to their arrival to Canada. Thus, it is important to address their mental health needs in a culturally-appropriate manner.

DEVELOPMENT OF KAREN DEPRESSION TOOL

In order to address this issue of a lack of appropriate assessments and to develop a culturally sensitive screening tool for depression, the authors conducted a project which investigated understandings of depression among a number of Karen men and women. Karen refugees participated in focus group discussions designed to explain how this particular population understands and deals with the symptoms commonly regarded as "depression." Participants were presented with a short story derived from the works of Wig et al (1980) and Karasz (2005) describing individual's emotional and somatic symptoms of depression. The story was used as a means of portraying depression without using technical language.

> *For the past two weeks Sara/Nick had felt that something was wrong with her/him. S/he complained of different troubles at different times; troubles such as headaches, pains in the stomach, general weakness of the body, difficulty breathing and tiredness. S/he couldn't do her/his work as well as s/he usually could. Often during the day her/his eyes filled with tears, and she/he felt intense sadness. Her/his close friends and relatives couldn't cheer her/him up. S/he found it difficult to fall asleep and s/he lost her/his appetite (Wig et al., 1980; Karasz, 2005).*

The purpose of using this story was to ascertain the perception of depression from Karen refugee men and women. Specifically, we wanted to gather information from the focus group participants (1) whether the individual in the vignette has a problem/illness; (2) what are the symptoms this illness/problem; (3) what other terms and expressions one would use to describe the illness/problem; (4) the causes of this illness/problem; (5) who the person in the story should seek help from: mental health professional, general practitioner, or somebody in the community; (6) stigma associated with mental health issues.

IMPLICATIONS

The results of this project assisted us in identifying the ways in which Karen refugees express depression, the symptoms they associate with depression, their help-seeking behaviour, and the stigma associated with mental health issues. More importantly, based on the results of this project we were able to develop a culturally-sensitive screening instrument for use with Karen refugees in screening for depression. Early and accurate detection of depression in this population will improve Karen refugees' well-being by providing timely and appropriate interventions. This project, and the screening tools developed from it, offers health care professionals a reliable and valid tool that will help them identify Karen men and women who are depressed. The second phase of this project, where the screening tool was implemented, proved the Karen Depression Screening tool to be more accurate in detecting depressed patients than a widely used Western measure of depression (i.e., Center for Epidemiologic Studies Depression Scale).

The accurate differentiation of depressed and non-depressed patients is important in the Karen population as they are inclined to present with somatic symptoms to their primary care physicians which then lead to misdiagnosis when the physician is not aware of Karen cultural expressions of depression. Thus, our findings indicate it is crucial that the health care professionals use the Karen Depression Screening tool to screen them for depression first before a costly search for unlikely diseases and unnecessary treatments. Early detection and treatment of depression will greatly assist the settlement process of refugees, will support strained family and community relationships, and in the long term provide real cost benefits and improved health outcomes for the Karen population. Identification of culturally distinctive features of depression will also help to pave the way for sensitive clinical inquiry and the effective delivery of therapy for the Karen population. Being aware of culture-specific symptoms of depression among Karennis can assist clinicians in minimizing misunder-

standings of depressive symptom expression, in developing therapeutic alliances, and preventing Karennis from premature treatment termination.

The use of culturally appropriate screening tools in primary health care will also lessen the burden on clinical services because somatic complaints cause excess visits to clinics. Furthermore, accurate screening of depressed and non-depressed patients can help prevent excessive utilization of the health care services and the high expenses associated with such services. Also, the availability of a culturally sensitive screening tool will enable researchers to have insight into prevalence rates of depression in these groups.

Health care professionals and researchers can use the data collected from our project to begin to identify meaningful patterns and important cultural differences within larger ethnic populations. Such instruments are also helpful in understanding cross-cultural differences and similarities in the experience of mood disorder. The results of this study may also prove valuable to researchers and public health professionals in developing culturally-relevant interventions for Karen and other ethnic minority groups.

CONCLUSION

Refugees often experience numerous traumatic events; forced displacement from their homes/countries, loss of/separation from loved ones that can increase the likelihood of developing depression, and they continue to face numerous challenges as they settle and integrate into the mainstream society. Early and accurate detection of mental health problems will improve the well-being of *new Canadians* by providing timely and appropriate interventions. The results of our project show that with careful planning and execution, it is feasible to construct culturally and linguistically valid instruments for screening for depression in the primary health care setting.

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