Community Consultation and Mediation with Racialized and Marginalized Minorities

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Shirlette Wint

This chapter documents the process of mediation with ethnocultural communities in public and private spaces. It examines how communities construct and use community and institutional networks to support their social identities and cope with crises in individuals or within the group. I will describe the salient concepts that inform and shape my community consultation and mediation practice and present strategies for successful mediation work with ethnic communities that protect and support cultural heritage. The consultation approach is illustrated with examples of communities effectively negotiating both "non-dominant" and "dominant" cultural resources in their interactions with mainstream sites of services. I will also draw from my collaboration in research studies of the experience of racialized minorities and my work as a culture broker for the CCS.

The last 30 years have been taxing for community activism in North America, with severe cutbacks in social programs and increased poverty among the urban poor. Within this landscape of social disparity, I have worked towards developing tools in clinical practice that can assist individuals and groups with a history of marginalization in self-development and solidifying their often contested identities. The modern and postmodern struggles of marginalized groups have largely coalesced around economic issues, and equal service and representation in the public spheres of government, health, and politics. Moreover, in Canada, there has been a shift in ethnic community development, from a focus on social class and economy to a focus on *multiculturalism* and *cultural competency*. Unfortunately, this shift has occurred at a time when ethnocultural communities are being pressured to assume more of the responsibility to address social problems within their communities, with local and federal governments holding them accountable to resolve these issues on their own with minimal intervention and support.

Though my practice is not limited to one particular group, a large proportion concerns itself with finding ways to bring about collective and individual transformation among marginalized individuals and groups in Montreal's metropolitan region. Often these group and individuals—be they Indigenous, Afro-Canadians, immigrants, gays and lesbians, single parents, or sex trade workers—are struggling with the futility of trying to compel governments and social institutions to recognize them as whole and authentic. As a psychotherapist and cultural consultant for the last 20 years, I have employed a wide range of experiences in the fields of social work, elementary education, community mental health, and community action research to evaluate and find creative solutions to complex social problems.

The underlying principle behind this work is the belief that fundamentally, each individual has

S. Wint, M.S.W. (✉)
88 Rue Charlotte #1108, Montreal, QC,
Canada H2X 4E2
e-mail: swint67@hotmail.com

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an innate need and desire to experience a sense of belonging in the society in which they live and that when this need and desire goes unfulfilled, the individual or group is left with a sense of marginalization and emotional distress. It follows then that those who find themselves marginalized may need assistance to achieve better social integration and a sense of belonging in civic society (Merton, 1978; Taylor, 1994). In this approach to clinical practice, the client may be an individual, family, or community. Healing or transformation is achieved in a variety of ways, through group workshops, individual consultations, and working collectively with other community organizations, churches, or government agencies. The collaborative work with other community systems during the treatment process is designed to result in a transformative experience for both individual and group. In several instances, there has been a trickle down or spillover of therapeutic benefits to the larger society, particularly when art and culture are used as vehicles of communication in psychosocial interventions in community settings.

Often the first step in working with the marginalized is to convince the individual or group that they must become visible to themselves regardless of whether the dominant structures of the society recognize them as such. Concrete ways of accomplishing this task are through assisting the client in seeing the abundance of riches of knowledge, history, and tradition that exist in their own cultural group and helping them recognize how their community has contributed to the larger society. When community interventions are successful, the group is able to embrace the past, see progress, and view the future with optimism and agency rather than seeing themselves only as voiceless victims. This last point is essential: the majority of youth and adults who experience identity crises and who are seen in community organizations for mental health problems come from families where clarity about the internal and external forces of oppression is significantly lacking in their everyday interactions with family and other close relations. Knowing that they are constantly under the gaze of the dominant society impacts on how Blacks or other racialized minorities go about developing aspirations, how they formulate their hopes and expectations, and how they conform to or reject specific social norms. Consciousness of always being under the gaze of the other also impacts on marginalized individuals' capacity to take a critical distance from their lived experiences (Frankenberg, 1997). In therapeutic work, it is evident that consciousness of oppression sometimes limits the individual's ability to express feelings and develop effective strategies for living including the use of irony, conceptual experimentation, and creative transgression.

Regardless of the setting and the problem, a common goal in most clinical work with marginalized minority communities is that participants will benefit from a transformative process that leaves them feeling that they belong to a larger community, the human community, which encourages them to reach beyond the borders of their own cultures of origin when searching for solutions in times of crisis.

This approach to community consultation and mediation might be termed *transculturality*. This term is an apt metaphor for my practice since it evokes the movement from one social position and worldview to another that is the focus of cultural consultation. The consultant also embodies movement in that professional itinerancy is intrinsic to working with marginalized communities who often do not have the infrastructure or budget to hire full time professionals. More importantly, movement often begins with the client's migration from one country to another, from a small rural region to a big city, from a homogeneous community to one with a diversity of cultures, or from a poor heterogeneous inner-city neighborhood to a more homogeneous suburban community. Although the majority of migrations are successful, when coupled with social adaptation difficulties, the experience can be extremely difficult for some groups and individuals.

In most contemporary urban centers, individuals have experiences with cultural difference and diversity on a daily basis, on public transportation on the way to work, at the grocery store, in interactions with their children's caretakers, at the bank, in church, and so on. Similarly, nearly everyone is inhabited by multiple cultural beliefs and practices, some from their own cultural background, others from the diverse cultures that

they negotiate and transact with every day and which they use more or less unconsciously when appropriate. Whatever its developmental roots, one's identity is constructed over a lifetime and is not fixed or stagnant but renegotiated and transformed as difference is encountered. Although these encounters are determined largely by social forces beyond the individual, the texture and outcome of such encounters remain the responsibility of each individual as an active participant in a pluralistic society.

Through acculturation, the individual and group embody cultural responses that become second nature and that can be sources of strength and support during times of crisis. The aim of community consultation and mediation in mental health is to recognize and exploit this cultural capital to address mental health problems. Of course, in everyday life, many marginalized groups do this very well and deal with common mental health problems on their own or with resources of the family and community. They consult mainstream systems for diagnosis and treatment when they have especially puzzling or serious health problems or when ordinary remedies and solutions prove inadequate and the problem persists. As a result, by the time people arrive for consultation in the mental health system, they have their own ideas of what may be wrong and what is likely to be helpful. Sometimes, the mental health practitioner's diagnosis is contested because the client has a different interpretation of the problem or they have multiple concerns and feel that the issue that the mainstream system has identified as the focus of treatment is not the primary problem or priority. This is illustrated by work with a mothers' group in an inner-city neighborhood in Montreal.

Case Vignette 10-1

I was contracted by a community center for women to provide individual and group consultation to 12 mothers with an average age of 28, the oldest being 42 and the youngest 14 years old. Most of the mothers were without partners. Several had histories of violent, abusive relationships with the fathers of their children. The meetings were held at the center twice per week, with one day devoted to a 2-h group meeting and the second day for individual consultation. The goal was to help strengthen participants' life skills through group and individual counselling. The group selected topics of interest, which included overcoming poor self-image, clarifying needs and wants, becoming assertive, anger management control, conflict resolution, and healing emotional wounds. Most of the mothers were born in the Caribbean or South Asia. A few had early African-Canadian ancestry, tracing their history to the first slaves brought to Canada rather than more recent migration from the Caribbean.

When I had been working with the mothers for about 6 months providing group and individual consultations, one of the mothers, a 42-year-old woman of Caribbean origin and mother of 4 went through a very difficult period with her ex-partner who had tried to strangle her. During my individual and group work with her, it became apparent that she was experiencing some cognitive difficulties which had led to other problems related to housing, finances, and parenting. Her distress was apparent to the other group participants who tried to support her by normalizing her feelings and encouraging her to talk about her situation. Working closely with the client and the workers of the community organization, we tried unsuccessfully to get the client to recognize that she was showing signs of cognitive dysfunction. While the client accepted the support and accompaniment regarding her physical health, she seemed indifferent to our concern regarding her mental health. We concluded that because the client perceived herself as occupying an already marginalized role in her family, she did not want to add the stigma of a mental disorder to an already very long list of problems. While she smiled and listened to

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our concerns, she showed no desire to follow-up with an evaluation with a psychiatrist. Eventually the client was successfully treated for a gynecological problem, but staff at the community center continued to have concerns for her mental health. She had mentioned to several workers that she was afraid to take money from the automatic bank machine for fear that she was being followed. As a result, she often did not have enough money to buy groceries to adequately feed her four children. Knowing that her ex-partner had followed her in the past, we did not entirely dismiss her fears. However, when the complaints began to intensify, the director consulted with the client's sister who confirmed that the client had a history of odd behavior but stated that it was "nothing to worry about". The client had no history of alcohol or substance abuse. She had not finished high school but had no intellectual disability.

I worked with the director of the center to devise an intervention plan that provided necessary support to the client in a way that did not stigmatize or alienate her. The plan recognized the client's strength, notably her care and attentiveness for the well-being of her children. Even on very cold and wet days, she travelled across town to bring her 2-year-old son to his play group and participate in the center's group for mothers. The intervention plan consisted of a worker from the center accompanying the client to the bank once a month to ensure that she withdrew enough money to buy a month's groceries for her family. (Monies from Social Welfare were deposited into the client's account once per month.) The support of the local community health center (CLSC) was also enlisted to monitor the client's progress through home visits. The home visits helped to structure the client in how she carried out parental tasks and eventually helped to decrease symptoms of anxiety and paranoia.

In community consultations, it is in the area of mental illness that ambivalence or resistance to treatment is most apparent. The most common problems involve adjustment disorders accompanied by somatic symptoms that may be difficult to diagnose or treat. Historically marginalized groups, including women and immigrants, may shield emotional distress behind undiagnosed and complex physical ailments (Leccia, 2008; Ton & Lim, 2006; Whitley, Kirmayer, & Groleau, 2006a, 2006b). Dissatisfied by the response of the medical system, they look to alternative sources for healing. In African, Caribbean, and Indigenous cultures, nearly every form of food is thought to have medicinal value. Until recently, in urban settings, special efforts were needed to obtain the "natural" medicines needed for self-treatment. In today's global culture, health food stores with a range of food, herbal, and other remedies can be found in nearly every neighborhood in North America communities. While the diagnosis determined by biomedical practitioners may not be contested, for many people, there is comfort in the "creolization" of treatment, combining elements from different traditions in new ways. Multiple treatments may be used at the same time reflecting what makes most sense and seems to be most helpful for the patient (Lim, 2006). The cultural consultation work at the CCS supports this approach, as illustrated by this excerpt from one of cases in which I acted as a culture broker.

Case Vignette 10-2

Ms. Brown was a 44-year-old Black woman of Caribbean origin who was a refugee claimant, referred to the CCS by her treating physician. She also had a young son who had been placed in foster care by Youth Protection during her hospitalization and treatment and having her son return home depended on her getting well. She had been previously hospitalized and diagnosed with a psychotic disorder. At the time of hospitalization she was delusional and aggressive with auditory hallucinations. During the CCS interview, Ms. Brown

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expressed concern about the appropriateness of her past treatment. She did not see how the medication that her doctor had prescribed could really help her. She thought that it might alleviate some of her stress but did not believe it would cure an illness that had been caused by someone "working Voodoo" on her. She felt that only a spiritual healer could provide effective treatment by confronting the person responsible for making her ill. Her ideas that healers can manipulate the forces of nature and influence ordinary outcomes in everyday life were consistent with her cultural background. She had clear ideas about what would be necessary for her treatment, including structured fasting, meditation, and prayer officiated by someone who had understood the process of counterbalancing the workings of evil with good. Ms. Brown described how her mother had recovered from a similar situation with similar strategies.

Before coming up with a cultural model that met the needs of the patient, the CCS team and I, as the culture broker, worked closely with Ms. Brown to develop an appropriate treatment plan that included the resources she identified as potentially helpful for her healing. That included reaching out to the pastor of her church. As she began to feel more secure, I suggested that she be linked to community resources to provide her with a supportive social network by connecting her to a women's group that had several members of Caribbean origin. The community organization also provided her with a place to have supervised visits and reconnect with her son who had been placed in foster care by a Youth Protection mandate while she was hospitalized.

This vignette underlines some recurring factors in working with individuals from marginalized groups: the need to maintain control (hence the efforts to involve Ms. Brown in her treatment plan) and a reluctance to discuss past trauma with a preference to focus on concrete ideas and current tasks. Given appropriate and consistent support, many clients prefer to solve problems on their own. In this particular case, however, my knowledge of community resources enabled me to help the CCS team identify a community group that was the right match for the patient's needs. In addition, my sharing some cultural symbols of identity with the patient such as race, ethnicity, gender, and being a fellow immigrant likely facilitated a therapeutic alliance and encouraged the patient's investment in treatment and healing.

Immigrants and refugees migrate from their places of origin with spiritual and religious beliefs that can be a source of support during periods of stress as well as providing a language through which they articulate their concerns. In this case, Ms. Brown referred to "Voodoo", a term that has become common across Caribbean Canadian communities for referencing any kind of magical belief. Ms. Brown knew that the culture broker would understand her use of this term, which served to convey her desire for spiritual or religious treatment. In revealing to the team how she wanted to be treated, Ms. Brown also was indicating that she had inner resources that could be tapped to develop a treatment plan that included conventional psychiatric treatment. The consultation team made it clear to Ms. Brown that they respected her cultural competence and knowledge about her illness and came to an agreement with her that allowed her to use both conventional and nontraditional modalities, sometimes simultaneously. Ms. Brown acknowledged the benefits of having her symptoms of psychosis reduced with medication, but she also cited the benefits of having individual prayer sessions with her pastor.

Marginalization, Cultural Identity, and Choice of Adaptive Strategies

Two decades of working first with Africans of the Diaspora, first in New York City and then in Montreal, have led me to believe that many of the

mental health disorders that trouble this group are rooted in their response to racism and can be defined by what Frantz Fanon (1967), more than 40 years ago, termed a condition of 'wounded consciousness'. Fanon suggested that Blacks, as a social group, are at risk for difficulties in social adaptation which can lead to mental illness unless they free themselves from the subjugation of their identity by images provided by the colonizers, and reinvent more satisfactory images for themselves. Fanon wrote that Blacks exhibited a "neurotic personality" and attributed this to a collective awareness of a common experience of oppression and a shared history of colonization and slavery. Healing was possible through a collective catharsis in which collective aggression could be channelled. Though Fanon's thesis was grounded in the experience of marginalization of Blacks of the Diaspora, elements of this predicament fit the experience of other ethnocultural minorities and racialized groups in Canadian society. Taylor (1994), for example, argued that other cultural minorities struggle and succeed in Canadian society despite "an image of inferiority" perpetuated by the dominant culture which maintains a paternalistic relationship with cultural minorities.

Some of the ways that the phenomenon of "wounded consciousness" plays out in contemporary Canadian society are illustrated in the reflections of Dawn, an immigrant from the USA, who I interviewed for a study on the subjective well-being of Black Canadians. At the time of the study, Dawn was working as a physician at a Montreal hospital. Based on the discriminatory treatment she received from her peers and subordinates, she was convinced that racism flourished in her hospital because of institutional collusion. She was dissatisfied with her work arrangements but believed that she had to continue putting in 6-day work weeks because if she stopped, her White colleagues would consider her lazy. Over time she had become so discouraged with her experience of unequal treatment that she decided to distance herself from the subordinated identity associated with "Blackness". She commented:

> I cannot imagine the day when any society will not promote fair over dark. Yeah that's right. I don't know how it started but if we look in fairytales the princess was White, the witch was Black. I don't know how that started but I don't think that it will ever stop. I am reluctant to label myself as Black—why be associated with a negative stereotype? (Wint, 2000, p. 82)

Dawn's response to racism and exclusion involved knowing how to "play the game" and fit into the dominant mainstream culture. She was able to pursue this solution because of her professional accomplishments. For others, however, fitting in may not be an option because they lack the appropriate background or social status. Bourdieu (1977) suggests that a lack of "cultural capital" accounts for why some Blacks and other marginalized groups who do not come from "high status origins" do poorly in school and the work place. Some immigrant children and minorities from disadvantaged backgrounds may not have the "sophisticated vocabularies and precise information about how school [and mainstream society] work" (Plaza, 1996, p. 246) that Dawn used to navigate through university and professional training.

> When I was in university, I socialized with mainstream White students, and asked questions of professors. I banked on them remembering me for having made extra effort when it came time to distribute grades. Other Black students remained aloof and did not ask professors to clarify concepts they did not understand for fear of being labeled ignorant by what they perceived to be racist professors. Also, they did not mix with other White students but studied among themselves. In my view, they contributed to their own limitations by not increasing the pool of students with different strengths in their study group. Consequently, they did not always do well on exams. When you get to higher levels of education, all the concepts you need to learn are not written in books. The way you gather the information is by associating with your peers. A lot of times, I didn't get the answers, but you don't develop your ideas in isolation. You develop your ideas through interaction. (Wint, 2000, p. 53)

Dawn's strategies attempted to address some of the psychological challenges that come from prevalent stereotypes of Black and other racialized minority groups (Steele, 2010).

Although Africans of the Diaspora face similar challenges to identity formation as a result of racism and resultant social exclusion, their attitudes to this predicament and coping strategies

are diverse. They also differ in the emphasis they place on racial affiliation as an aspect of their identity. However, most share a collective history of "enforced subordination and oppression" (Eyerman, 2004). For these reasons, clinical assessment and treatment must consider the level and degree to which particular forms of marginalization are currently affecting the well-being of the individual or group.

The pervasive experiences of racism in everyday life and their effects on identity influence help-seeking and treatment expectations. Many individuals in Montreal's Black communities do not perceive themselves as having ready access to tools or resources that could enhance their overall well-being. As a result, they expect that their personal goals and aspirations will likely not be met and their happiness not achieved. The need to have these basic expectations recognized and understood is one reason that patients may desire ethnic-specific treatment when possible (Wint, 2000).

The struggle for emotional integration and social belonging is as much a preoccupation for the group as it is for the individual. In Montreal, focus group research with parents and youths aged 14–18 of both genders from Caribbean and Filipino origins examined how their perspectives changed over time through their participation in groups that explored problem solving, building community alliance, strengthening school and group alliances, and developing a sense of connectedness to the dominant host culture. The focus groups took place in community centers and churches in Montreal. The study concluded that participants expressed pessimism and a reluctance to use mainstream sites of services to facilitate their integration into Quebec society (Measham & Wint, 2007). Participants could not envision a "harmonious integration" (Diener, 1984) or fulfilment of their life goals in Quebec society. Youth participants in particular, described severe marginalization and expected to confront further obstacles. Consequently, they tended to suppress their goals and desires, diminishing their chances to achieve well-being (Diener, 1984). While lowering their goals and expectations might be interpreted as an adaptive strategy, protecting youth from disappointment, if continued into adulthood, the result is a widening of the gap between immigrant youth and their counterparts in mainstream society. Rather than contributing to well-being, therefore, this self-handicapping creates more opportunities for disappointment, frustration, and failures for the individual and the marginalized group.

In community consultation, many of the clients that I encounter share similar backgrounds associated with lowered expectations and self-exclusion from mainstream society that aggravate their social marginalization and economic poverty. Research suggests that some ethnic minorities that have experienced racial discrimination may choose to underachieve academically because they do not perceive themselves as having equal access to the dominant forms of social capital needed for success (Carter, 2003). Thus, "many African American students may lower their academic aspirations, believing that high achievement will only benefit 'White', middle class students" (Carter, 2003, p. 137). The negative impact of common stereotypes may also function as cognitive biases outside of awareness (Steele, 2010).

Similar patterns of avoidance and self-defeat may occur in other domains. For example, young adults needing psychological support may hesitate to approach mainstream service providers in schools, clinics, or hospitals, worried that they will not receive a culturally sensitive response. In these cases, the individual or group is so immersed in their chosen or imposed identity associated with marginalization that they are unable to reach out for necessary treatment and support. In *The Nature of Prejudice* (1954/1979), psychologist Gordon Allport argued that individuals and groups prefer to confirm their prejudices about others who are different from them rather than revise their thinking. This conservatism applies to the targets of prejudice as well as to those who practice racist discrimination. This tendency to find evidence to confirm our prejudices persists even when the group disproves the stereotype. Allport maintained that, in the end, it does not matter how many times the individual or group dispels a commonly held perception of themselves, the assumptions about the devalued group remain intact. Toni Morrison wrote that "among

Europeans and the Europeanized, this shared process of exclusion—of assigning designation and value—has led to the popular and academic notion that racism is a 'natural', if irritating phenomena" (Morrison, 1992, p. 7).

While Allport was primarily looking at the damaging effects of prejudice on African-Americans, a similar process may affect other marginalized groups' perception of mainstream individuals and institutions, including health services. Groups that have experienced repeated exclusion tend to view dominant systems as intractable, and this may prevent them from benefiting from needed care when it is available. Stereotyping at its worst robs the individual and the group of their identities and reinforces false beliefs that can have costly and detrimental consequences for the group (Steele, 2010).

One might ask if groups find mainstream cultural institution so lacking in sensitivity, why do they not simply seek out the services in their own cultural communities? Unfortunately, the demand for culturally sensitive service far outweighs the supply of health institutions with well-developed programs addressing the needs of cultural minorities. In addition, there are not enough trained mental health professionals from marginalized cultural communities to serve and outreach to these minority groups. In general, stereotypes continue to dominate in health and other major institutions even after they have been reduced in academia, religious, political, and economic institutions that have been complicit or silent about the perpetuation of racism in the past. By networking and creating alliances with community organizations, churches, and some medical clinics in ethnic diverse neighborhoods, practitioners can mitigate the impact of marginalization.

The ambivalence of marginalized communities towards using mainstream services to treat their psychic distress is due mostly to concerns that they may not be received and treated with sufficient care and respect. They may believe that someone who looks like them is more likely to understand their everyday experience and address their clinical problems or predicaments. They may also fear that if they open themselves up to influences of the dominant culture they will be assimilated or absorbed into that more powerful group and lose their collective identity. Though Canadian society in the twenty-first century is becoming less ethnocentric and more pluralistic, marginalized ethnic minorities may still feel great apprehension about their ability to preserve individual and collective self-determination (Kymlicka, 1998; Leonard, 1997; Taylor, 1994).

Having worked both in marginalized and mainstream community settings, it is clear to me that the reluctance of some cultural minorities to use mainstream institutions is not due to a lack of awareness of available services. Rather, their infrequent and selective use of mainstream services reflects deeply held concerns about how they will be dealt with. When they have the opportunity to voice their feelings in a safe setting, many express the fear that they will be treated in a racist manner. Formal and informal discussions with community leaders in the Caribbean, Haitian, and Filipino communities support this impression. These leaders have also expressed a great deal of frustration and anger at being further disempowered when they protest about unequal treatment to agents of the dominant institutions and find that their complaints are dismissed or they are accused of being "overly sensitive" or, still worse, "playing the race card". Encounters such as these produce an intercultural impasse, exacerbating current myths, stereotypes, and biases, segregating groups and rendering the process of coping with mental illness or other psychic distress more difficult. It is particularly difficult to raise issues of racism and inequality when they are embedded in institutional practices. Referring to such institutionalized racism, Elliot and Fleras (1992, p. 336) write: "this type of racism is impersonal, unconscious, unintentional, and covert… and is the consequence of seemingly neutral rules, policies, or procedures that establish its distinctive character." Ruth Frankenberg (1997, p. 3) notes that such institutional dominance typically is "rationalized, legitimized, and made ostensibly normal and natural."

Recognizing structural and systemic forms of racism requires an awareness of larger social processes. When perceptions of inequality and injustice are dismissed as evidence of hypersensitivity or a

"culture of victimization", it becomes difficult for individuals and groups to identify and talk about their experiences of structural violence and everyday micro-aggression (Sue et al., 2007). Not being able to define and name racist and discriminatory acts when they are recurrent intensifies the psychological marginalization of minorities and makes it more difficult to develop productive and positive strategies for opposing social exclusion. In Western countries, the groups most often silenced by such dismissal are peoples of African descent, Indigenous peoples, gays and lesbians, and the poor.

Resolving racially charged situations when integration is the only imagined outcome presents seemingly insurmountable challenges, particularly when integration is defined as a one-sided process of submission to the dominant "White" culture. "What integration has meant for many Whites is that Blacks [and other non-Whites] had to interact with them on their own terms. Not only do many [Whites] not want to participate in other cultures, but they feel theirs is *the* culture" (Wein, 1992, p. 92). This is the current state of affairs in many North American urban cities and describes the climate in which many marginalized groups are trying to find place and space for themselves in mainstream societies.

In an interview for a study on the links between racism and the subjective well-being of Black Canadians, Joan a Caribbean-born, middle-class mother and business woman described her understanding and difficulty identifying racism when it appears.

> …because racism when it is presented, it is in such a covert way, it is something you feel and sometimes you question your feelings…I think people hesitate because others might think that it is your crutch to getting that advancement on the job. I think Blacks have a tendency to second guess themselves and ask "Am I really seeing what I am seeing? Am I really feeling what I'm feeling? Am I being paranoid? Let's give it another chance." That's probably why [Black] people don't come out and say "*racism*". (Wint, 2000, pp. 67–68)

In this climate of ethnic and cultural divides, it is imperative that mainstream institutions rise to the challenge of meeting the community health care and other service needs of our diverse population. It is important that these institutions are successful in their endeavours because it is often within these settings that people from different cultures meet for the first time, with a common concern and seriousness of purpose. Hospitals, community medical clinics, schools, and social service settings provide opportunities for people to enter into dialogue and construct new paradigms based on authentic expression and exchange of their experiences. The outcome of these first encounters may determine whether or not an individual or group will feel excluded or work towards integration into the larger Canadian society.

Negotiating Community Relationships: The Consultant as Insider and Outsider

Though my field of practice includes diverse marginalized groups, the position from which I practice is influenced by my racialized identity, ethnicity, class, gender, and political values—all of which make me sensitive or less responsive to specific issues that may come up during community consultation and mediation. As an Afro-Caribbean professional consulting with a wide range of individuals from Montreal's Afro-Canadian communities, I am mindful of the need for critical self-reflection in my work. In contemporary society, ideas, allegiances, and identities are influenced by immigration and globalization of economies and cultures. As a result, one cannot always recognize the extent to which one's cultural identity is the product of individual efforts at self-fashioning or reflects wider currents. When working with Black clients who interpret and make meaning of their social worlds in racial terms, there is an acute awareness that I too am governed by White dominance which impacts on the very language I speak and the clinical concepts I use. Unlike many of my clients, however, I look for meaning not in racialized constructs but in the emerging process of creolization that is shaping the global framework (Bibeau, 1997). This perspective allows me to seek out best practice models and to confront my own biases and hesitations regarding assumptions about racialized identities

and transactions insofar as they influence cultural models for interpreting the lived experiences or the experience of collective trauma of marginalized groups.

Mental health interveners do not enter the therapeutic space with a tabula rasa. Moreover, each encounter presents potential barriers and opportunities for a successful alliance that will promote the well-being of the individual or the group. Generally, sharing the same background and cultural affiliation as clients helps the processes of building an alliance, assessment, and subsequent mediation and resolution of personal or group conflict. However, there are times when clients have experienced so many traumas that they have become deeply suspicious of outsiders and resist efforts to explore areas that they feel are the private domain of the group. Additional time and care should be taken during evaluation of these clients, knowing that they may be reluctant to provide information about occupation, place of employment, or the nature of their illness experience or past medical treatment. Frequently, the reluctance to divulge personal information is related to fear about confidentiality despite reassurance. At other times, this reticence is simply normal behavior for the individual who is a member of a cultural community where secrets are considered necessary for survival and maintained through harsh social sanctions from one generation to the next. The sanctions against disclosure of collective secrets or private knowledge can go as far as ostracism from family and group. This practice creates an "us and them" relationship with the consultant, host country, and to some extent even with other ethnic minorities that share racial affiliation. There is an implicit agreement in some minority groups that they can never entirely trust the Other. This has been particularly evident in my work with clients from Haitian and Indigenous communities, who may be unwilling to name names or places, evading inquiry or providing vague responses. A member of the Haitian community who has travelled and lived in many urban communities commented, "as soon as you unmask a Haitian person another mask takes its place". Evidence of distrust similarly restricts the helping process when working as a cultural broker within the CCS process. At such times because of the initial wariness of the patient, the fact that the cultural broker shares a common background with the patient does not always break down barriers of resistance to what the patient may perceive as intrusive and unsolicited relationships. These barriers are easier to address in one-to-one interviews with the patient than when working with a multidisciplinary team or group consultation. In the one-to-one interview, patients also may be more likely to use cultural terms or colloquialisms to describe their experiences and concerns. With a team, on the other hand, there may be greater opportunity to pay close attention to body language and it may be easier to ask the patient for clarification.

While secrecy and distrust are understandable survival strategies and must be negotiated during the period of building the therapeutic alliance, they become especially challenging when treatment depends on individuals' capacity to examine painful collective experiences that remain difficult to articulate or "taboo" in their cultural communities. In the case of Africans of the Diaspora, where the public portrayal of the individual's cultural group often has been negative and they feel they have been unfairly judged, there may be great reluctance to risk repeating the experience in therapy even when the therapist is Black. This is a daunting position for second-generation Afro-Canadian immigrants who cannot even claim to have directly experienced a traumatic event, even though they manifest the symptoms of trauma, which DeGruy-Leary (2005) has come to describe as "post traumatic slave syndrome" among African-Americans. Slavery and colonization are no longer active institutions in North American but they continue to inform collective identity. However, these experiences are different for different individuals and groups within the African Diaspora.

Self-disclosure may be problematic for marginalized individuals who suffer from social isolation and do not habitually share their inner thoughts and feelings with anyone. When lack of self-disclosure impedes the clinical relationship, rather than viewing the client as uncooperative, the professional often can move the process forward by reevaluating with the individual, family, or group their therapeutic goals and treatment.

For example, when a young Haitian client declined to divulge information about her community, this posture brought to mind the conflicts within and between Afro-Canadian communities, divided by geographic location, cultural practice, religion, and language. Although these groups share a similar history of slavery, their contemporary experiences, including their migration trajectories and subsequent reception, have been different. A White consultant may not know about the tensions between Francophone Haitians and Anglophone Caribbean Blacks and may not recognize the nuances that go into building trust and forming alliances between these groups. Some theorists have invoked the concept of internalized oppression to explain why members of an oppressed group may come to have negative views of others like themselves (Freire, 1973). If these issues are not openly discussed, they can become major obstacles to sharing scarce resources and working together to achieve some level of empowerment and critical consciousness.

Given the segregated social spaces and experiences in North American communities, a White professional may have little knowledge of Black culture and may therefore tend to view the Black client in terms of mass-media stereotypes. To date, working through the issues of racism remains underdeveloped in the training of most mental health professionals. As a result, stereotypes in the clinical context often go unchallenged. This is especially so for psychotherapists and psychoanalysts in private practice, where the prevailing attitude seems to be "that an individual pays for a service and is free to choose to leave, or to remain, depending on the way they view the quality of the service" (Thomas, 1999, p. 146).

Defensiveness is almost always a part of the therapeutic relationship with marginalized individuals who perceive their problems as stemming from external sources. The resistance encountered in the clinical encounter is often greater when working with vulnerable groups than with the general population. There is more of a tendency to externalize and blame problems on the external world, "the system" "institutional racism", and so on. There is also an inclination to be reactive and quick to defend the individual and the group against what is perceived as general rejection from dominant institutions. In such situations, the consultant must be ready to absorb the hostility and suspicion that clients may direct towards them. I can usually tell from a client's body language that they do not expect me to support them in their interpretation of the problem. It is as if the clinician is being placed on trial and will most definitely be found guilty. At such moments, the interaction can be helped along if the professional can bring attitudes of humility, respect, empathy, and compassion to the encounter. An effective response from the professional validates the client's feelings while firmly but gently reminding the client of his or her therapeutic goals, which are usually to learn more effective coping strategies even when faced with events that are largely beyond their control.

Pride occupies a huge place when working with clients of Caribbean, Haitian, and African heritage, especially first- and second-generation immigrants. As a result, some individuals may present clinically as reserved, closed, or passive. Many middle-aged Caribbean women show a kind of stoicism as if they take pride in not showing any vulnerability. They may reveal that no one really knows them and what they are really feeling. Often these individuals have suffered a great deal of loss, including failed relationships, those left behind in the migration process, and the unmet expectations of full integration into Canadian society. These issues are common among immigrants from different backgrounds and may be reinforced by particular cultural or religious values. Thus, in reference to working with Vietnamese families, Axelson (1999, p. 449) writes that:

> restraint of personal feelings and unwillingness to disclose personal problems or to reveal emotions will work against traditional counselling goals of self-disclosure. Therefore, openness as a basis of understanding and talking out problems in a traditional counselling process will not be possible to the same degree as with most culturally assimilated Americans.

For this reason, it may be very difficult to get these individuals to participate in group therapy due to their fear of verbalizing feelings and confronting others. Successful interventions rely heavily on the consultant's ability to help individuals

reinterpret their history in ways that give them a more positive view of past experiences and future prospects. This must be done in parallel with efforts to help them deal with psychic pain, while attending to other situational stressors such as finding jobs, improving academic performance, obtaining health care, and building relationships with others that will improve their quality of life.

External social determinants should be acknowledged as probable causes of clients' difficulties, but if these are the only contributors recognized, then an impasse may rapidly develop. Individuals must be encouraged to explore other contributors to their difficulties. If the consultant stays stuck in generalities, the client will likely follow suit. This holds true for the CCS model of intervention, which involves time-limited consultation with one or two encounters with the patient. Generally the approach that works best in this situation explicitly asks the patient for their collaboration in an effort to understand the clinical problem and assist them in finding appropriate resources to address their own specific issues and concerns.

While racial or cultural differences between client and consultant can influence the process of assessment and intervention outcome, so can other social dimensions such as class, gender, and sexual orientation. The following three vignettes illustrate diverse roles that culture plays in the consulting and mediation process.

Case Vignette 10-3

James was a 21-year-old Black male of Caribbean origin. During the 5 years he had lived in Canada, he has suffered cruel treatment repeatedly from a relative who had helped him to settle in Canada. Despite the abusive treatment received by the patient from his relative, he spoke of her as someone towards whom he bore "no ill will". He was not evasive but he did not show any eagerness to reveal information about the relative that had treated him badly. It was clear that he felt a certain loyalty to her.

In some patterns of migration, immigrants may be received initially by a "hub household", which provides shelter and support while they get their footing in the new society. As Bashi (1997) has described, however, some immigrants have ambivalent feelings towards the hub household (or host family) while feeling indebted to the larger hub network as a whole. This sense of indebtedness may prevent the patient from voicing anger towards the hub household. Bashi also noted that receiving immigrants sometimes exerts pressure on a new immigrant; the newcomer will comply with unreasonable requests because they do not want to be perceived as ungrateful back home. As a result, they will be reluctant to "betray" the hub household even when that relative is cruel and makes unreasonable demands that threaten their well-being.

Case Vignette 10-4

Mary was a middle-class, middle-aged Black woman of West Indian origin who was referred by her treating psychiatrist. Her presenting problems were physical and emotional difficulties related to her marriage. She described preferring a Black therapist in private practice as opposed to using the public mental health systems fearing that workers in those systems would apply stereotypical generalizations, labels, and prescriptions. After several sessions, Mary mentioned that her husband was under a "spell" put on him by his mistress. She did not elaborate but admitted to having consulted someone who "knew about these things" before coming to see me. I did not pressure her for further clarification because I knew that individuals of West Indian origin, particularly first-generation immigrants, often look for magical explanation in times of crisis or mental disorganization; usually this type of explanation is considered in parallel with an ongoing search for other explanations and sources of help. I allowed Mary to determine how much to explore this magical explanation for what had happened

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to her. As it turned out, she was more interested in developing a deeper understanding of the complexities of her marriage and how she had come to view herself as victimized and powerless.

Being able to recognize to what extent the client shares the traditional cultural values of the group and where there is acceptance of dominant society values can be key to successful interventions and engagement between individual and professional. A clinician more interested in the exotic might have placed an unnecessary focus on Mary's nontraditional and non-Western belief systems. The resultant intervention would have approached Mary's problems as being due to external forces, and this might have reinforced her sense of disempowerment and prevented her from working through the issues she was facing in her marriage.

Insider/Outsider: Black Therapist/ Black Client

Since I work in the area of cultural and community mediation, I expect and welcome Black clients who seek a Black psychotherapist. The process of working through presupposes that the professional is able to face the challenge of resisting the powerful countertransference issues that arise when a Black patient expresses self-hatred, without becoming either overly nurturing or rejecting (Kareem & Littlewood, 2000). Some Black patients, when they discover the professional is Black, may unconsciously expect unprofessional and inferior treatment, which can create tension in the first encounter. This negative expectation may be revealed in expressions of surprise when the encounter unfolds in a professional manner as indicated by comments like: "I didn't know what to expect" and "you're so professional." Although the process of building trust and rapport may be accelerated when client and consultant share the same cultural heritage, ethnicity, or racialized identity, individuals may still anticipate that because of the power differential in the relationship, the consultant will treat them with the same paternalism and condescension they expect from members of the dominant cultural group.

Other pitfalls that occur when the consultant shares the same ethnicity as the client are related to the unexamined values and shared assumptions that the professional may not question. For this reason, it is critical that consultants carefully consider their own values, the values of the larger society, and their professional values as they are expressed in the norms and goals of clinical work (Axelson, 1999, p. 47).

A climate of trust can be encouraged if professionals acknowledge that specific aspects of the individual's difficulties might be an outcome of how that individual's ethnocultural or racialized group has been impacted by socioeconomic or political marginalization and exclusion or other forms of structural violence. However, while such externalizing explanations can be a legitimate defence against racist practices of the dominant society, when they serve as the core of collective identity, they can undermine the strength of the group and the individual. Unfortunately, this remains a common framework which many Africans of the Diaspora use to construct their identities, despite evidence that the large majority of Blacks are "informed, advanced, self-reliant, and capable of [resisting] institutional racism and discrimination" (Smith, 1996a, 1996b, p. 6). The following case example illustrates one individual's struggle to create and sustain a social identity that is based on frameworks other than race:

Case Vignette 10-5

Jean is a 25-year-old Canadian-born Black male of Haitian origin. He was referred for anger management by his Employment Assistant Program, because he specifically asked for a Black therapist. During the first consultation, he described more than ten incidents of racial discrimination at work. This included derogatory comments made about him, being asked to do work that was

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not in his job description, being asked to do dangerous work that was against company protocol, and having his pay withheld or being fired when he brought the problem to the attention of supervisors. Jean also described many troubling symptoms, including difficulty sleeping, anxiety, dizziness, sadness, involuntary movements in his legs, and an obsessive tendency to scratch himself. He spoke of how angry he was and that he needed help coping with financial and other stressors. Finally, he described never having had access to positive role models in his immediate environment. He had few satisfactory social relationships and his only outlet was weight training and boxing after working 8–12 h per day.

Jean was allotted 8 h of counselling by his employer. I saw Jean a total of 7 times over a period of 3 months. Most consultations went on for 75–90 min. Community consultations are different from traditional therapy sessions in that they often last longer than the usual 50 min and the interval between consultations may be 3–4 weeks. Consultations with Jean were more systematic because he was in a crisis situation. Over the 3-month period that I saw Jean, he became unemployed and changed jobs twice and was often extremely distressed. He had two distinct stances: part of him was optimistic and looked forward to a better and brighter future in Canadian society; hence, he refused to accept being treated as "inferior" and wanted to see the good in some of the very people he described as rejecting him. At the same time, he also rejected Quebec society and talked of moving out of Quebec to what he hoped would be a less "hostile" environment in the neighboring province of Ontario. However, Jean's dominant experience, expressed in the therapeutic space, was that of a hurt individual who had a hard time understanding why his White Québécois friends with the same level of education and vocational training, and the same background of poverty, were doing better than him. He described having no support from family, noting that his mother was "in another reality" and his brothers were indifferent to his situation.

The intervention focused on providing Jean with emotional support and a great deal of discussion about the complex social relations that resulted from his being from a cultural and ethnic minority. Efforts were made to reinforce his self-confidence by having him draw upon personal experiences of previous successes and reminding him that prior successes could be repeated in the future. This also served to restructure his negative expectations as well as providing him with strategies for coping with the fear that he would become aggressive each time he encountered an obstacle.

By providing Jean with the tools to restructure his perception of his present situation and the social condition and status he aspires to, or feels entitled to, he was able to transform his overall level of satisfaction and greatly improved his capacity to advocate socially and professionally on his own behalf (Campbell, 1981). Jean was given specific tasks and oriented towards social activities that eventually broke a cycle of social isolation and widened his social supports. He was also directed towards other community resources for legal counselling on discrimination and labor rights. A follow-up phone discussion with Jean showed him grappling with some of the same issues; he had a job that he hoped to keep, he was sleeping better and felt more hopeful. He still had plans to leave Quebec.

This vignette illustrates some of the contradictory experiences of marginalized racial and cultural minorities. They may feel vulnerable, yet come to the consultation bringing feelings of resentment and may be confrontational. They may present themselves as victims who seek recognition and reparation for past wrongs,

while remaining steadfast in the belief that they should be self-sufficient and only seek outside support when situations reach crisis proportions. In most cases, marginalized individuals do not hold their employers accountable for discriminatory treatment. However, they may gain a sense of empowerment just by knowing that this recourse is open to them. As Plaza suggests, regarding Africans of the Diaspora, they "carry within their psyche a certain core arsenal of mobility strategies and philosophies to help them avoid disappointment and to realize a sense of achievement in whatever circumstances they might be in" (Plaza, 1996, p. 268). These coping mechanisms are used whenever unpredictable situations are encountered.

Jean's protests against discrimination in the workplace occurred as individual acts, not as part of a larger political movement. In the Black and Caribbean communities with which I am most familiar, the forms of expression and the ways to manage psychological distress have changed over the last few decades, with more mediation taking place in the private sphere than in public settings such as was common during the struggle for civil rights during the 1960s. During the fight for civil liberties, Blacks customarily fought together, gained strength, and took comfort from their shared struggle. In contemporary Canadian society, the emphasis is on individuals' efforts to achieve success, and it is more difficult to conceive of a collective identity and a sense of belonging within a global culture that has abandoned more socially conscious politics in favor of a superficial political correctness that satisfies neither dominant nor minority culture. Several quality-of-life studies support the belief that Blacks as a group have been experiencing a collective post-Civil Rights disenchantment and inertia (Diener, 1984; Hughes & Thomas, 1998; Thomas & Holmes, 1992). Hunt (1996, p. 279) notes that Blacks are nearly as materialistic as Whites, yet even when successful, they tend to cultivate an identification with "the perception of the general condition of [the] group rather than [the individuals] own socio-economic status." This phenomenon of passivity is often encountered in the initial CCS consultation. Fortunately, within the Black and Caribbean patients, the personal characteristics of pride and an all encompassing need to avoid becoming dependent on others serve as motivating factors in getting patients to exercise individual agency.

Best Practices in Community Consultation with Marginalized Groups

Marginalized individuals and communities usually perceive their life chances and opportunities as being less than that of the dominant majority. Hence, their expectations, values, interpretations, and definitions of fulfilment and success in life may differ from those of the majority. These communities tend to be sceptical of consultation and mediation processes that promise them positive outcomes despite obviously unequal power relationships. From the start, the consultants' role in these unequal encounters is to work towards cultural safety by providing emotional support to groups or individuals who may be more acquainted with exclusion and rejection than with recognition and acceptance. Because of the general distrust of outside intervention, an initial period of relationship building is a crucial part of any consultation. There is no place in this process for the consultant who has a clinical attitude of non-engagement and emotional distance. It is not enough to provide vulnerable individuals with a name and phone number for help. They need to be assured that sites of referrals will be welcoming or they will not follow through on referrals or will wait until their situation becomes critical before they act. Marginalized individuals need to have access to culture brokers, mediators, guides, or advocates who can help them negotiate potential conflicts that may impede their treatment when hospitals, clinics, or social service institutions are dismissive or resentful of requests for cultural accommodation. Whether in public or private settings, marginalized individuals may require assistance to decode the bureaucratic systems that can address their needs. A first contact telephone call with a medical or other social institution may have to be made from the consultant's office. Follow-up is also essential for success; these

hard-to-reach clients are easily discouraged and therefore difficult to motivate. Often, however, all they need is one success in negotiating the diverse service systems to make the transition from dependency to autonomy. The importance of this outreach has been clearly demonstrated in integrated care for depression with low-income minority women in the USA (Miranda et al., 2006).

The more marginalized the group or individual, the more difficult it may be to gain their trust and build a therapeutic alliance, especially if the consultant discounts or ignores concrete and practical concerns, hence the importance of ensuring that the issues worked on are those identified by the client and not only those chosen by the consultant or the referring clinician. Even when they are very distressed, many immigrant and marginalized clients may want to solve practical problems before they agree to explore underlying causes to their difficulties, which may be rooted in early psychic traumas. In the setting of the community organization or church, tangible and sometimes material resources must first be provided along with abundant emotional support in order to create a favorable environment for the individual or group that can facilitate the use of available services. Practical interventions may include getting someone from a community center to accompany an individual to medical appointments to help clarify confusing diagnoses, assisting with writing letters for college applications, providing babysitting resources, directing individuals towards mutual support groups, finding a general practitioner, or obtaining free legal advice.

Capacity Building

Often marginalized individuals and groups present a defensive or angry exterior because they lack self-confidence. They live in a society in which they have few opportunities to see themselves reflected in a positive way. As a result, they have difficulty developing trusting relationships with others outside of their families and geographic communities. The consultant's task is to convince clients that they have the ability to learn the necessary skills to direct their lives onto a course that will bring them a greater sense of focus and fulfilment as well as lessen psychic conflicts with society. This may involve a shift from helping individuals to reconfigure their own ego functioning or ways of coping to understanding the social context and dynamics of their cultural group and the political processes of marginalization in relation to the dominant society. At such times, the writings of Paulo Freire (1973) appear more relevant than those of Freud or other psychodynamic theorists. Freire's teachings about anti-oppressive practice and its link to psychic liberation provide a crucial underpinning for community consultation practice. Freire's work leads to an emphasis on dialogue founded on respect in which the professional works in partnership with the patient to find viable solutions to the problem at hand. This approach can often successfully engage disadvantaged and resistant clients. In community consultation and mediation, much work must be done to expose and demystify the complex relationships between dominant social systems and the diverse responses of clients who are subjugated by those systems. This "pedagogy of the oppressed" can contribute to strengthening internal resources and building social capital which will allow individuals and communities to advocate for themselves as they discover alternative ways to regain their mental and physical equilibrium.

Consistent validation of marginalized clients' experience fosters trust and builds the therapeutic alliance. While initial trust and rapport are facilitated when the consultant and the client share cultural background or ethnicity, their subsequent development depend on the consultant's skill in communication (Axelson, 1999, p. 430). The communication style used during the consultation process with marginalized individuals is central to creating a professional relationship that will be therapeutic for the individual and leads to greater collaboration between client and consultant. In contrast to the open-ended style promoted by psychodynamic psychotherapy, in community settings, many individuals may prefer more directive communication styles that focus on concrete suggestions, plans, and explicit encouragement.

The cultural consultant is not an expert on the client's experience or lifeworld. The individual's or the group's thoughts and feelings must be elicited and explored throughout the process of assessment and intervention. One aim of consultation is to assist individuals in their search for explanations of their difficulties and help them develop alternative ways to understand and address their dilemmas. Providing individuals with concrete information about their background and collective history can help them to determine where their own experience fits with these larger social forces and cultural paradigms. The consultant does not impose ready-made meanings but helps prepare a canvas on which the client can begin to sketch a healthier version of themselves.

Marginalized individuals may be uncertain of their place in their communities of origin and the larger society and may need confirmation or validation of their feelings especially when they are unaware of the historical factors that have shaped their cultural group. Even when they know the history, they may have never given themselves permission to examine the wounded parts of themselves and they may be afraid to do this without guidance.

> Rejection of primary culture is likely to lead to the confusion and self-doubt that is found in a marginalized existence. Consultants who seek to assist in the resolution of a state of marginality need to understand the client's psychodynamics, the two cultures, and a process that will facilitate movement toward desired goals. (Axelson, 1999, p. 431)

The cultural consultant thus must work with both the individual psychodynamic processes of defensiveness and vulnerability and the collective social and political processes that undermine the sense of power and well-being of both groups and individuals.

Conclusion

After more than 25 years working with marginalized groups in private and public settings, it is clear that much remains to be done to make mental health services safe and sensitive to difference. Despite gains over the years, mainstream institutions still compel individuals to fit into treatment models in which they do not recognize themselves. Professionals are not encouraged to create and explore alternative treatment approaches that are responsive to culture and context. Openness to diverse practice models would surely provide much food for thought and move the idea of integration to a level beyond the restrictive dichotomies of professional versus traditional, conventional versus alternative, and, implicitly, "us versus them."

Regardless of the domain of practice, the marginalization and exclusion of certain groups is a serious challenge for a liberal democratic society like Canada (Taylor, 1994). Addressing this disparity is not only the responsibility of government and policymakers, local mental health administrators and professionals can also take a stance on issues related to unequal service delivery and discrimination. There is a need for a dialogical process that reflects Canada's diverse cultures (Leonard, 1997)—one that recognizes the value for pluralistic societies and credits diverse cultures with their own knowledge and prescriptions for well-being.

The development of culturally safe mental health practice models is crucial to the Canadian vision of a multicultural and pluralistic society in which government is ethically and legally bound to take the lead since culturally marginalized individuals and groups may not have the capacity to form effective movements of resistance around issues based on race, ethnicity, religion, sexual orientation, and class.

As more and more social movements are formed around culture and ethnic identity with a focus on cultural politics rather than on broader issues of class and racial inequalities, health professionals will need to be both culturally competent and politically aware so that they can make the links between their clients' individual situations and larger social structural issues afflicting society. If health professionals are to be good advocates for their clients, this social, cultural, and political awareness must be an essential feature of mental health practice. Together with their clients, culturally competent professionals should be able to deconstruct the themes of identity, cultural difference, and intercultural misunderstandings

and learn how to work as partners to develop effective treatment plans. Interactions that are rooted in the principles of humility, respect, and openness to the other can help individuals develop positive visions of themselves including a shared collective identity and cultural solidarity with the dominant society, focused on hope for the future. Such strategies would allow each cultural group to find some measure of identification with the dominant culture without concern for loss of cultural or ethnic identity.

In a social climate of continuing racial, ethnic, cultural, and linguistic divisions within Canada's multicultural society, the ability of health care professionals and cultural brokers to respect the uniqueness of each group including that of the "host" country is an opportunity to contribute to positive social change, for the benefit of both the individual and the larger society. From a structural perspective, there needs to be ongoing dialogue between the institutions that provide services and the communities they serve. This dialogue can help heal some of the wounds of misunderstanding and mistrust that have developed over a long period of time. Overcoming structural inequalities at institutional levels will also require an admission that the process of decolonization is incomplete and continues to be a formidable task for both colonizer and colonized. Here we can draw on the experience of Blacks, feminists, and Indigenous peoples who continue to struggle to find their space and place in a Eurocentric and often male-dominated social and economic world. Unanimously, these groups have cited consciousness raising, critical thinking, and critical education as being essential to achieving social equality for members of minority cultures.

As professionals striving to work in ways that are in harmony with the needs of a culturally diverse population, it is important that we enter into a dialogical relationship with our clients. This should include inviting clients to share their knowledge about us and to reflect on what they believe health care services can and should do for them. This form of "empowerment" is a reasonable starting place for a relationship based on respect, trust, and genuine interest in the other. This is not an abstract political ideal—the truth is, systemic and structural oppression affect us all and eventually erode our sense of well-being. Respect for cultural diversity in mental health services is an opportunity for all concerned to renew their commitment to the values of racial, ethnic, and cultural diversity that are part of multiculturalism.

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