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LIKE MINDS, LIKE MINE
Whakaitia te Whakawhiu i te Tangata

Like Minds

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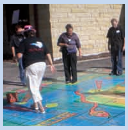
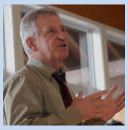
WHAKAITIA TE WHAKAWHIU I TE TANGATA

WHAT'S INSIDE





Language proviso
In this issue of the newsletter, we recognise that individuals prefer to use different terms – 'self-stigma' or 'internalised stigma' – to describe the same experience. In quotes and profiles we have reflected people's own preference and in all other articles we've chosen to use the term 'internalised stigma'.

Internalised stigma – the silent issue

Internalised stigma is a silent issue – many people are not aware that their friend or loved ones are feeling that way

Internalised stigma is an issue for many, if not all, people with experience of mental illness. Yet when you are struggling to fight the discrimination in your own community, how do you deal with the discriminatory voice inside your own head?

Surprisingly there has been little research into this issue as Debbie Peterson, Senior Policy Analyst and Researcher, Mental Health Foundation and her project team found out when they started delving deeper.

"The focus of the *Like Minds* project has traditionally been on stigma and discrimination but self-stigma has also been recognised as an issue.

"When we started investigating what has been done in this area we discovered that people know and understand very little about it – and that lack of information is both in New Zealand and internationally."

Even defining or describing what self-stigma is can be a challenge.

"Some people say self-stigma is simply discrimination turned in on one's self," says Debbie. "It's also been described as low self-esteem, a fear of discrimination, or the opposite of personal empowerment, but these

Continued on page 2

Continued from page 1

definitions become problematic for different reasons.

“It is possible for people to have fine self-esteem and be personally empowered, while occasionally experiencing self-stigma. People may also fear discrimination for good reasons and yet not feel self-stigma.

“Saying that self-stigma is discrimination turned inwards puts unnecessary blame on the person with experience of mental illness, instead of on society.”

The project team came up with two definitions of self-stigma:

1 negative thoughts or feelings towards yourself based on the fact that you have a mental illness

2 self-belief in negative stereotypes that have become linked to the experience of mental illness

They also noted that there is a difference between self-stigma and self-discrimination.

“Self-stigma,” says Debbie “is an attitude, for example you think you’re useless because you have a mental illness.

“Self-discrimination is behaviour that arises from this attitude, for example you stop yourself from applying for a job because you feel useless.”

Debbie says that because it affects most people with experience of mental illness at some stage in their life, research into self-stigma is very important.

“Self-stigma stops people from doing things – from not applying for a job, to not seeking help, to not wanting to disclose our experiences of mental illness.

“Because it may stop us reaching our full potential, it is important to do something about it.”

The project team working on the self-stigma research intend asking people associated with the *Like Minds* project about self-stigma and self-discrimination.

Debbie Peterson and Alex Barnes from the Mental Health Foundation’s Wellington office are coordinating, managing and undertaking this project. The research is being overseen by a reference group whose members are: Mary O’Hagan, Sarah Gordon, Dean Manley, Vito Malo and Lynne Pere.

As part of the research, the Mental Health Foundation will be running a series of focus groups asking people with experience of mental illness about their experiences and ideas for reducing self-stigma and its effects. They expect to start these groups in 2007, finishing the project by year’s end.

In the meantime, let’s see what some of our community say about their experiences of self-stigma…

Profile one:
Cheri Ratapu-Foster

Cheri initially experienced mental illness after the birth of her first child. It was traumatic and still has an impact on her life. But Cheri has chosen to embrace what happened to her and now works within the mental health sector as an independent consultant. She is committed to making a difference in the lives of others (like herself) and was contracted and has recently written a National Survey for Child Adolescent Mental Health Services.

> “I don’t sweat the small stuff, I chuck the rubbish in the bin and it stays in the bin!” Cheri Ratipu-Foster

“I can’t speak to my family about my experience. Because they weren’t around when I went through it, they seem to be uncomfortable about the subject and avoid talking about it.

“It’s really hard to explain, but I think it’s always watching yourself, wondering what other people – friends and whānau – are thinking. It doesn’t engross my life – I know who I am, where I come from, being tangata whaiora – but it impacts my life when I’m questioning how much to share with people without being judged, wondering if I will be protected, professionally as well as personally. I mean, people who see my CV would be able to see that my roles would rely on personal experience of mental illness, but when I’m talking to people in a broader sense I always wonder how much to share.

“When it does come up I brush off their remarks, I’m not phased by them and don’t respond, it doesn’t hold me back. I don’t sweat the small stuff, I chuck the rubbish in the bin and it stays in the bin!

“The work I do keeps me going and it’s about passion. Looking at every opportunity and deciding yes or no.

“For Māori most wellness comes from being connected to their hapū, iwi, land, nature, maunga, awa, aroha, by incorporating unspoken principles such as aroha, tika and pono. It can be a problem for urban Māori (such as me) feeling disassociated with what’s going on back home, not being actively involved. It’s really about balancing stuff in all facets of life!”

Profile two:
donna donna

donna donna is a staunch shaker and mover specifically of women’s and lesbian’s rights and has been involved in the mental health consumer movement for many years.

“I have my own hang-ups about my perceptions of mental health, like I hate it when people make a presumption of me because of my mental health issues, but then I turn around and do the same thing to myself sometimes. To me that’s internalised stigma.

“Right now I’m having to go to the mental health team, and I feel kind of embarrassed and humiliated that I have to walk in there, and people might see me walking in, it’s really stupid because I go there a lot for work, but now because I’m going there for my own personal reasons I don’t want people to see me coming in here.

“I am involved in volunteer and paid work, so I stood back from some things and resigned from another, because I need to take time out from a lot of stuff and thought that it would be helpful to step back and not stress myself even more.

“I guess I’m having a good moment right now, I know they respect me because looking back on the first day I went in there they were really considerate as to how they could meet my needs and I’m really grateful for that.

“[When I became distressed] initially they told me to sit down and then they came back to me and said would you like somewhere more private? [How often is anyone offered privacy?] Then they worked the team around so that I could see a female worker when it was a male worker on call at the time.

“Part of [internalised stigma] is how society perceives you, but part of it is the way you are brought up as well. You’re given all these messages as you’re growing up like – what nutters are like and if you behave in a certain way you’ll go to the nuthouse and things like that – and that sticks with you. No matter how hard you try to work through that in times of crisis that old stuff comes back up.

"It's a constant battle to get rid of the old ways of thinking especially when I'm in a really stressed, distressed state. Also, because I've had so many experiences of being unwell, each time to some degree is a little bit better because I've learnt more ways to do things for myself.

"It's stereotypical behaviour that I think is the main thing behind the stigma, it's stereotypical whether you're lesbian, have experience of mental illness, or both. People seem to have this picture of what you must look like and how you must be, that you need to be avoided and all that kind of stuff.

"I set up a support group, 'Dykes Supporting Dykes' which was a confidential group and even there we had problems with people speaking about their issues, the biggest thing was, who's going to realise I have mental health issues?

"In saying that, I know there is a lot more awareness and acceptance and it has improved in the last ten years but the stigma and internalised stigma is still there. Internalised stigma is probably the bigger problem because stigma is looked at and there's education around all that but nothing's really done on internalised stuff."

Profile three:
Shery Mead

Shery Mead lives and works in New Hampshire where she consults on the issues of recovery, trauma and mental health, systems change and the development and implementation of peer operated services.

> "Many people have gotten messages about 'what's wrong with them,' implicitly linking their 'problems' to their self identification." Shery Mead

"For many people it has had to do with trauma and abuse, people having their power and voice taken away from them. In other words, our reality gets constructed when others impose 'truth'. Then we end up in the mental health system and we get 'treated' for what has now become 'our problem'. We then learn to 'cope' with our problems rather than 'unlearn' how we've learned to think.

"Hope is absolutely a key facet of recovery and linked to internalised stigma (see 'What Recovery Means to Us' article on her website) . People have to have hope in order to believe they can make changes. People are told about the chronicity [of their illness] and their hope is taken away. People with shared experience are living examples of hope that contradicts chronicity.

"[Language is also important] given that language creates our reality, finding language that implies growth and change as opposed to "coping" or maintaining.

"We see [the effects of internalised stigma] all the time when people say "I can't do that". They don't have the belief in themselves that they are capable of doing something. One part of peer support training is on world view. I ask people to take a good look at how they see the world and how that affects what they do, how they think, and how they interact with others.

"I have [been affected by my own internalised stigma]. I live in a very small town and a long time ago I was very involved in everything – teaching music, parenting – then I went crazy, lost custody of my kids and was hospitalised a number of times. The town didn't treat me so well after that. What's interesting is that I'm sure no one even thinks about it, but I still carry old assumptions about what they think which keeps me isolated. I still struggle now with seeing people and doing 'normal' things like being a soccer mum.

"[Being a professional in mental health], I don't feel quite as scared or ashamed in my work – but other parts of my life have been affected [by internalised stigma]. I continue to try to put my work into practice in my own life.

"Anytime people hear others' stories there is almost an immediate credibility. If this connection is fostered, we can learn from and challenge each other's old beliefs. However, peer support is not just about role modelling, in fact that can be a dangerous area, giving advice etc. More importantly it is about building connections which then leads to learning and growth for all."

For more information about Shery's work see her website www.mentalhealthpeers.com

By Darcey McDonald and Debbie Peterson

What can people do about self stigma?

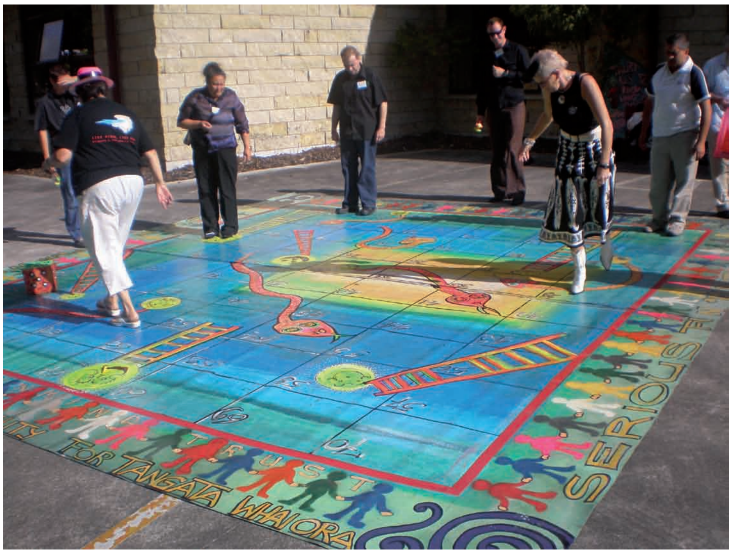
At this stage there are no specific self-stigma guidelines on what you can do for yourselves, how others can support you and where you can go for help.

It is recognised as an issue and with Debbie's team investigating self-stigma in more detail, it is hoped that supportive information will be developed in 2008.

In the meantime, believe in yourself and your own ability to fight negative stereotyping whether it is in your own head or someone else's.

Debbie Peterson presented the Mental Health Foundation's project looking at self-stigma faced by people with experience of mental illness at the Like Minds National Provider Seminar/Hui in Hamilton in March 2007.

Like Minds National Provider Seminar/Hui



Top Left: Serious Fun 'n' Mind's snakes and ladders game formed just one of the Seminar's workshops

Bottom Left: VIBE stand – the journey of the Vibe mural

Above: Mary O'Hagan, Mental Health Commissioner, focused on anti discrimination and how our views of other 'taboo' subjects have changed over time

Nearly one hundred people attended the *Like Minds* National Provider Seminar/Hui on the 21 and 22 March 2007 at the Kingsgate Hotel in Hamilton.

The Seminar was open to all providers, national contractors, *Like Minds, Like Mine* partners, allies, consumer organisations and networks, and provided an opportunity to meet the new *Like Minds* programme leader Darryl Bishop and to discuss the National Plan, to network/share ideas and have some fun.

Highlights included:

1 Darryl Bishop's keynote speech, which opened the Hui. Darryl discussed the success of the *Like Minds* campaign and how this work can be translated into effective strategies to direct future *Like Minds* work.

2 Debbie Peterson, senior policy analyst/researcher at the Mental Health Foundation, shared new research that looks at employment experiences of people with experience of mental illness. She also hosted workshops on self stigma.

3 Ivan Yeo from the Like Minds team at the Mental Health Foundation discussed how the *Like Minds* message is being brought to Chinese communities and the challenges faced.

4 Jane Wardlaw from Draft FCB spoke about phase four of the *Like Minds* television and radio commercials which look set to be launched in July 2007.

5 Mary O'Hagan discussed the perpetrators of discrimination and discrimination philosophies.

6 A workshop on the second day provided a chance for delegates to discuss, make comment and inform the content of the *Like Minds* National Plan that is currently being established.

Evening entertainment on the first night provided fun in the form of a Mexican themed night, with sombreros, nachos, cacti and a selection of Mexican themed food.

Roy Brown and his band Black Snapper provided fantastic music which saw plenty of people up on the dance floor enjoying themselves.

Darryl Bishop, programme leader, *Like Minds, Like Mine*

Despite a Bachelor's degree in Psychology from Liverpool university in 1991, working in the field of mental health was not an obvious choice for Darryl Bishop.

"Even then I struggled with some components of mental health services and could not see what role I would play" he says, "I felt that services under estimated the social and personal impact of diagnosis."

So he took a complete left-hand turn and worked as a barman, security guard and also trained and worked as a sous-chef in Liverpool.

"At the time it was just what I needed to do," Darryl says, "And although many people couldn't understand why – my family was always fully supportive of all my decisions."

He surprised people again when he was drawn back to the field of mental health and trained as a mental health nurse/therapist.

After brief experience of acute mental health services he started working in early intervention programmes with young people and has not looked back.

"I still wasn't happy with a solely diagnostic approach, but I knew I was in the right environment and as I developed professionally I found I was starting to work with people to address their symptoms and helping them understand their experiences instead."

In 1999, he moved to New Zealand and continued his work as a mental health nurse/therapist with the Kari Centre. In his new role he was encouraged and supported to incorporate his ideas into delivering services.

"One of my biggest 'wow' moments when I first came to New Zealand was when I attended a recovery training programme.

"Suddenly all the things that I'd been doing and had felt were intrinsically right were put into context and affirmed."

Darryl went on to deliver recovery training to other mental health professionals.

In 2000, while at the Kari Centre, he helped establish LEAP – the Liaison Education Adolescent Programme and www.headspace.org.nz. He returned to England for a few months in 2002 and then returned to take on the LEAP Co-ordinator's role later that same year.

"LEAP is a youth-based mental health programme that was introduced into schools in Auckland. It takes a holistic approach to mental health and talks about what contributes to a mentally healthy environment (for students and teachers) in the broadest possible terms.

"It was a fantastic project to be part of."

Youth Horizons beckoned next and for two years Darryl worked to develop broad community services for young people. One of the projects he is most proud of is the Ministry of Social Development funded Youth Transition Service in West Auckland.

"The Henderson project was one of the first five of its kind in New Zealand and it is a really valuable service.

"It aims to transition school leavers – without a plan for their future – from secondary education into the next stage in their lives, whatever that might be."

Throughout all his jobs, Darryl had been aware of the *Like Minds* programme and clients were always telling him that the key factors holding them back were the stigma and discrimination attached to mental illness.

"So I was delighted to have an opportunity to join the Ministry of Health in 2005 and to find myself working with Gerard Vaughan and even more thrilled when I was appointed into my current role.

"*Like Minds, Like Mine* started as an awareness programme but has since morphed into so much more than that."

Darryl says that he wants the momentum created by *Like Minds, Like Mine* to increase in the next five to six years and he is particularly keen to develop services addressing institutional discrimination and young people and discrimination.

"The first ten years have seen a shift in societal awareness and behaviour. The challenge now is to give people the tools to recognise and address discrimination."

By Cate Hennessy

Darryl Bishop, programme leader, *Like Minds, Like Mine*

Professional highlights

- Developing early intervention services in UK and NZ
- The LEAP initiative
- Youth Horizon's Youth Transition Service in Henderson

Mentors and influencers

- The influence of people working in the recovery movement.
- Amazing individuals like former colleague Clive who told me: "the most important things are to listen and to treat people the way that you would like to be treated."
- Ministry colleagues – like Gerard – who bring passion, craft and a high level of relationship building to their work.
- My family – especially my mum who has always supported me.

Key strengths in NZ mental health

- The recovery movement
- The leadership of people who have experienced mental illness
- The influence of a Māori understanding of mental health

Reviewing self-stigma literature – what Debbie Peterson discovered

Debbie is senior policy analyst/researcher at the Mental Health Foundation and has recently completed the first draft of the self-stigma literature review. The review investigates international research into the definitions, causes and effects of self-stigma, as well as how to combat it.

You've recently completed an international literature review on research about self- stigma; did you find a conclusive definition?

The definition that people feel most comfortable with – and the most common definition – would be that it is discrimination turned in on oneself.

Another definition of self-stigma is that it's the belief of not being as good as the others and internalised discrimination is the action taken because of that belief.

Then there is the international language issue – in New Zealand we use the term internalised or self-stigma, and the belief is that discrimination is what others do, and stigma is what we do to ourselves.

The US uses self-stigma and public stigma (discrimination), the belief is that stigma is an overarching concept and discrimination is one aspect, or behaviour that comes with stigma.

This makes reading the overseas literature quite confusing.

Which countries did the studies come from?

There is not a lot of research on self-stigma. The studies we used came mainly from the US and UK, and there were some Canadian studies as well. In New Zealand, there is no literature on it except for a small mention in the *Respect Costs Nothing* (MHF, 2004) report where we looked at the fear of discrimination being one aspect of self-stigma. There also isn't any literature on consumer's own perceptions or experience of self-stigma.

What are your thoughts on self-stigma?

It is an important concept because it stops people from seeking help. Personally, I think that most people with experience of mental illness will feel it [self-stigma] at some point in their lives. But maybe, interestingly, the more 'out' a person is about their experience, the less they feel it.

Research is really important because it will help us to find out what self-stigma means to people.

Because I'm open about my own experience, most of the time I don't feel it. But, sometimes it hits you in the face. When I'm giving presentations to people who've seen me at my worst it sometimes hits me, but I'm able to pull myself back pretty quickly.

How are you able to do that?

Practice makes perfect I guess. For the first few presentations I was really nervous but then I noticed that people really appreciated and wanted to hear about this stuff.

An important point is that self-stigma is not always bad. One author from the literature review states that the opposite of self-stigma is personal empowerment. The literature also pointed out [that] self-stigma is not necessarily negative for people. It can motivate people to overcome it and use it to do positive things in their life. Self-stigma doesn't necessarily lead to self-discrimination.

What can people do to overcome it?

The point of the research is to find out how people do overcome it. We do know that some people react negatively and it affects how they then get on with life, but some people use it positively. Very few people with experience of mental illness have been asked about self-stigma, to find those answers.

Where to from here, following on from the literature review?

We're planning to hold a few focus groups around the country, asking people how they perceive self-stigma, how it affects their lives on a day-to-day basis. It's important to get it from the people themselves. The question of 'what is it?' is relevant to find out where it comes from – the current assumption being that it comes from discrimination.

Debbie Peterson and her team reviewed 55 research papers on self-stigma. Some of the most informative ones were:

Corrigan, P & Kleinlein, P (2005). ***"The impact of mental illness stigma"*** *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change P. Corrigam, Washington D.C. The American Psychological Association: 11-44 (This focuses on an American view of the differences between stigma and discrimination).*

Shih, M (2004) ***"Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma"****. Annals of the American Academy of Political and Social Sciences, 591: 175-185 (Looks at ways of overcoming stigma)*

White, R (2004) ***"How Stigma Interferes with Mental Health Care: An Expert Interview with Patrick Corrigan, PsyD"*** *Medscape Psychiatry and Mental Health 9(2) Accessed at http://www.medscape.com/viewarticle/494548 (Looks at the implications that stigma may have on people's lives – you have to login to this website, but access is free)*

By Darcey McDonald

Becoming ‘one of them’

Mary O’Hagan, Mental Health Commissioner

“My first admission to a psychiatric hospital was unforgettable, primarily because I had to make a major and sudden identity transition from ordinary citizen to psychiatric patient.

“I had to acknowledge I was now ‘one of them’ – a loony, a nutcase, a mad person.”

Faced with a sudden drop in status, there were three responses open to me:

a. decide there had been a terrible mistake and that I wasn’t really ‘one of them’, or

b. decide that I was ‘one of them’, and because they were inferior I must be inferior too, or

c. say to myself, “yes I am ‘one of them’ but they’re OK and so am I”.

For various reasons, I was lucky enough to be able to find the third response almost straight away.

Internalised or self-stigma is extremely common; very few people with mental health problems could say they have never experienced it. It is defined by the feelings of guilt, shame and inferiority people experience because they have mental health problems.

Ken Wilber, a contemporary American philosopher believes these feelings are the ‘psychological metabolising’ of the stigma and discrimination individuals with mental health problems absorb from the external world.

One way of looking at this stigma and discrimination, is through the four quadrants model Wilber developed (*see diagram*). The model helps people adopt an all-embracing worldview when they are trying to understand or change something and any successful change process needs to include efforts in all four quadrants.

Because all human experience and activity can be placed in one of these quadrants, we can use this model to check if New Zealand agencies are covering the whole territory in their work to reduce stigma and discrimination.

Stigma describes what people think and feel internally either as individuals or as a collective, whereas discrimination describes what we say or do as individuals or as a society.

When stigma (internal process) and discrimination (external process) are applied to Wilber’s four quadrants, we can describe them as:

- individual interior – stigma towards self
- individual exterior – personal discrimination
- collective interior – stigma towards others
- collective exterior – institutionalised discrimination

The four quadrants model suggests that reducing self-stigma should be a key strategy in any comprehensive effort to reduce stigma and discrimination. But few organisations, either here or overseas, have developed significant research or services to address self-stigma (in the ‘individual interior’ quadrant). It’s therefore encouraging to see that the Mental Health Foundation has begun some research into the experience of self-stigma. (See Debbie Peterson’s literature review, page 6.)

Mental health services (assuming they are not discriminatory) are perhaps the best placed to take on a major role in addressing self-stigma. Some of the service options to consider in helping people overcome self-stigma are:

- A recovery-oriented service system where service users are treated as full human beings who have self-determination, hope, choices and a sense of belonging.
- The development of peer support and recovery education services.
- Opportunities for service users to lead and work in services, thereby becoming positive role models for other service users.

(These approaches will be more fully described in Te Hononga: Mental Health in New Zealand in 2015 and Beyond, *to be published later this year by the Mental Health Commission.)*

We urgently need to turn our attention and efforts to self-stigma, the most neglected of the four quadrants.

By Mary O’Hagan

THE FOUR QUADRANTS FOR STIGMA AND DISCRIMINATION

INDIVIDUAL INTERIOR **(Internal thoughts & feelings)** *STIGMA TOWARDS SELF* *eg shame or embarrassment at having mental health problems*	**INDIVIDUAL EXTERIOR** **(Individual’s language & behaviour)** *PERSONAL DISCRIMINATION* *eg NIMBY protest, bullying person because they have mental health problems*
STIGMA TOWARDS OTHERS *eg belief people with mental health problems are violent or are not fully human* **(Cultural norms, values & beliefs)** **COLLECTIVE INTERIOR**	*INSTITUTIONALISED DISCRIMINATION* *eg unfair exclusion from insurance cover, segregated services* **(Systems, organisations, laws, rules)** **COLLECTIVE EXTERIOR**

Internalised stigma and culture

"Healing, especially in the realm of the psyche, is enacted through the symbols of the surrounding culture. The psychiatrist and the 'shaman' alike heal by manipulating the symbolic framework that they share with their respective patients."
— Arthur Kleinman, Rethinking Psychiatry

How does your own culture or adopted culture affect the way you view your own mental illness? Does the internalised stigma that you may feel as an individual compound with the layering of culture? And is the cultural affect a negative or positive influence? Does it contribute to wellness or to ill health?

According to Debra Stein, for many cultures in the world, the symbols they draw on to define mental illness are not those of Western medicine that many of us are familiar with – they are instead rooted in the traditions of their country's indigenous people.

In Morocco, for example, along with the twentieth century influence of Western psychiatry, people also draw on other traditions for an explanation and treatment of their mental illness. There are the Berber traditions of sorcery (sHour), seers (fquih, seHara), and spells/curses (tretat). They also wind in the eighth century legacy of Islam and the Koran's demons (djnoun – or singular djinn) and the twelfth century influence of Sufism's holy men (marabouts) and divine blessing (baraka).

In one incident, a fquih who had a genuine interest in his client's well being worked alongside the psychiatrist to help comfort and calm the young man.

There are many other examples around the world of how culture influences the opinions of mental illness – and through that people's own opinion of themselves.

A person experiencing schizophrenia could have delusions of sainthood in Ireland (which used to be a pious country), fear they are being spied on in the technologically advanced USA, believe they are being publicly humiliated in Japan (where social conformity is preferred) and seen as spiritually gifted in other non-Western cultures.

In Sri Lanka, Nancy Waxler discovered that the person experiencing mental illness is not seen as being responsible for the illness: his self remains unchanged, even though his body or soul may be possessed. "If he follows the appropriate prescriptions, then it is believed that his symptoms will disappear and he will quickly and easily return to normal. There is no stigma attached to mental illness; no one believes that the patient is 'different' and should be treated in a new way after his symptoms have gone."

However, in much of Western psychiatry, Ruth DeSouza says that internalised stigma and racism intersect on many levels. "As ethnic people are already marked as deviating from the norm in their countries, a further invalidation based on culture and mental illness affects a person's identity.

"They lose their sense of who they are and where they fit into a world."

Ruth believes that the way forward is for mental health service providers to be sensitive to the culture of people with experience of mental illness.

"There is room for non-traditional medicines and approaches to mental health which could alleviate alienation and disconnection [especially] in migrant communities, which might address stigma and racism."

What can mainstream mental health service providers do?

Ruth says that at an organisational level "there should be an emphasis on systems developing cultural competence" and no expectation for the person to educate themselves (in their time of need).

She thinks merely being sensitive is limited, instead organisations should go for:

- Cultural competence: clinical cultural competence (staff training and workforce development, education of the ethnic communities at large, develop standards)
- Organisational competence (recruit ethnic workers, form partnerships with ethnic community organisations)
- Systemic cultural competence (ethnicity data collection)
- Linguistic competence (interpreters, language materials).

What can mental health professionals do?

- Encourage cultural competence in your organisations.
- If you are working with someone whose cultural experiences are different from your own, seek cultural guidance from that person's family and/or community.
- Learn to communicate using language that allows that person to draw strength and find 'wellness' from his or her own or their adopted culture.
- Think about your own biases and assumptions about how the world works and how you as a health professional work to support people who might have different ways of being.

Ruth DeSouza says that understanding about cultural diversity and different cultural needs leads to cultural safety for those people seeking support for their experience of mental illness.

She believes that New Zealand still has a way to go before they catch up with the decade of migrant and refugee influx, but a broadening and deepening of cultural safety can only improve the quality of health care for all who live in New Zealand.

Māori

For Māori, good health is recognised as being dependent on a balance of factors and these have been represented in a number of Māori health models which are metaphors for the important dimensions of Māori health.

Te Whare Tapa Whā
Mason Durie's Whare Tapa Whā model of health (1994) describes four components which represent the four walls of a house and the idea that if one wall fails, the house will fall. Reflecting a Māori perspective of health, te whare tapa whā includes consideration of:

- Te taha wairua – spiritual health
- Te taha tinana – physical aspects of health
- Te taha hinengaro – emotional and psychological wellbeing
- Te taha whānau – the social environments in which families live

Te Pae Mahutonga
Te Pae Mahutonga is a Māori health promotion model developed by Mason Durie (1999) and represents the Southern Cross. The four central stars represent four key tasks of health promotion; Mauriora – cultural identity, Waiora – physical environments, Toiora – healthy lifestyles and Te Oranga – participation in society. The two pointers represent Ngā Manukura – community leadership and Te Mana Whakahaere – autonomy.

Te Wheke
Rose Pere (1984) provides us with the concept of Te Wheke, the octopus, to define family health. Pere describes the head of the octopus as the whānau, the eyes as waiora or total wellbeing for the individual and family, and each of the eight tentacles as representing a specific dimension of health. The dimensions of health are as follows; wairuatanga – spirituality, taha tinana – physical wellbeing, hinengaro – the mind, whanaungatanga – the extended family, mana ake – the uniqueness of each individual and family, mauri – lifeforce, te hā a koro mā, a kui mā – the breath of life from our forbears and whatumanawa – the open and healthy expression of emotion. The tentacles are interwoven and this represents the close relationship between each of these dimensions.

Source: Māori Public Health Action 2003–2004

Pacific Island

Pacific people take a holistic approach to mental health. "Our mental wellbeing is usually affected when other parts of our lives are also not going too well." For example, "when our physical and spiritual wellbeing is not right, then our mental and emotional wellbeing will also be affected."

Pacific people believe some of their greatest strengths are their culture and spirituality. These are nurtured through the 'institutions' of family, community and church, which hold the answers when our mental wellbeing is affected in some way.

Source: headspace.org.nz

Pacific people are a little less likely to use mental health services than any other group in New Zealand.

The Pacific island community use innovative health models such as the 'Fonofale' created by Fuimaona Karl Pulotu-Endemann have promoted holism and continuity. Similar to Durie's (1994) Te Whare Tapa Whā, the Fonofale model uses the metaphor of a Pacific Island house and incorporates the values and beliefs of various Pacific Island groups.

Source: *Sailing in a new direction: Multicultural mental health in New Zealand*, Ruth DeSouza

Chinese

Ivan Yeo credits different cultural beliefs as a factor in the experience of internalised stigma. He says that Chinese people might believe mental illness is a weakness and that to counter this belief it is important to encourage the idea that it has nothing to do with who they are – they are not defective.

In Malaysia (where Ivan grew up) they didn't talk about mental illness. It was something that people were put in institutions for, and there was no hope for recovery.

He also says that language can play an important role in overcoming internalised stigma, especially when English is a second language. If people don't understand, and don't have the language to articulate, they can hate themselves more.

Source: Ivan Yeo, Project Manager, Chinese *Like Minds, Like Mine* project (Mental Health Foundation)

Surveys suggest that depression as we know it is an apparent rarity in China. Chinese, and other non-Western patients, simply don't report the same symptoms of depressed mood, feelings of worthlessness and guilt and general lethargy that Westerners do. Researchers theorise that this is because Chinese are less likely to make distinction between mind and body and attach a greater stigma to mental illness.

Source: 'Put yourself in my shoes', Noel O'Hare, *Listener* 2004

By Dean Manley and Cate Hennessy

Sources:

Views of mental illness in Morocco: Western medicine meets the traditional symbolic, Debra Stein, 2000
Sailing in a new direction: Multicultural mental health in New Zealand, Ruth DeSouza, 2006
'Put yourself in my shoes', Noel O'Hare, *Listener* 2004
'Stigma, racism and power', Suman Fernando, *AEN Journal*, 2007
Access issues for Chinese people in New Zealand. Auckland, Ruth DeSouza and N Garrett, 2005.

Useful Books

Fate, spirits and curses – mental health and traditional beliefs in some refugee communities.
Dr Kathy Jackson. Rampart publishers, 2006.

Culture and Mental Health: A comprehensive textbook
Kamaldeep Bhui & Dinesh Bhugra. Hodder Education, 2007.

If you have a story to share about your experiences with stigma or internalised stigma in a cultural setting – then please contact us by email (hayley@mentalhealth.org.nz) or by post (the Communications Department, PO Box 10051, Dominion Rd, Auckland 1446)

Warren Lindberg – fighting self-stigma

“Reducing discrimination requires people to change their behaviour… [and] individuals to assert their right to be treated with dignity and respect.”

Warren Lindberg, keynote address at the Valuing Madness conference October 2006

Warren Lindberg has had a lifetime of both personal and professional experience of stigma and discrimination. He believes that the mental health consumer movement parallels many other human rights movements in that discrimination and stigma is based on ignorance and misinformation. He shares his thoughts on self stigma…

How do you define self-stigma?

In the purely biblical sense, stigma derives from the [stigmata] on the hands of Jesus. This [metaphorical] mark indicates that you, as a person, are in some way damaged or branded as shamed and disgraced.

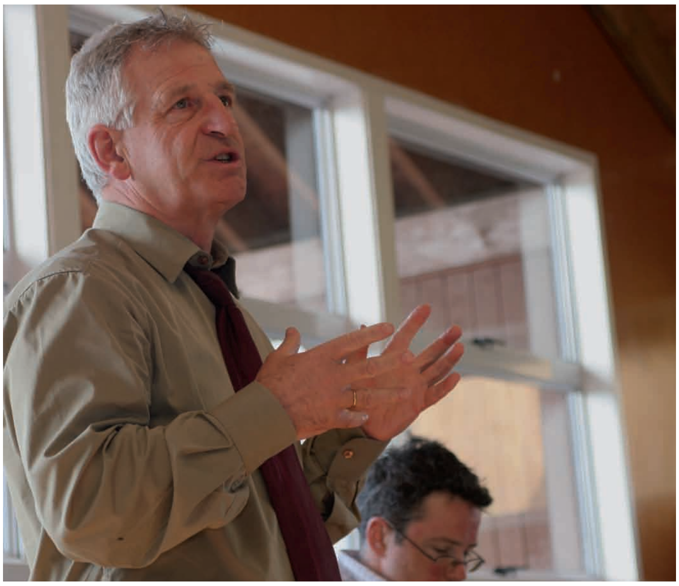
In today’s society, such branding leads individuals to accept social marginalisation from people who feel uncomfortable about their “damaged” status. The stigma makes society and often the individual consider themselves less than fully human.

How does self-stigma affect people?

The insidious nature of stigma, and especially self-stigma, is that you can’t tell a person with experience of mental illness from anyone else by looking, hence the constant worry about disclosure. This kind of stigma is more about the invisible damage than the visible – mental illness, like homosexuality, is often hidden through shame and embarrassment at being “different”.

In my experience, self-stigma makes people avoid socialising, either with people who share their stigma to avoid being identified as “one of them”, or only with those who share the stigma to avoid being treated as “different” and “other”.

Self-stigma often makes people accept their status as “damaged goods”, accept any communication that they are different, less-than-human and shouldn’t participate fully in community life. So they lose their sense of place and belonging – falling instead for a faulty identity.



Warren Lindberg, Group Manager, Public Health Operations, Ministry of Health.

This in turn leads to marginalisation and misunderstanding by others, leaving the stigmatised person continuing to feel uncomfortable about being somehow “different”, and both not inclined get to know each other.

Even when the stigma is legally removed, it can take much, much longer for individuals and society to let go of their differences and find freedom from self-stigma.

For example: In the 1980s, the homosexual law reform bill (Homosexual Law Reform Act 1986) was passed and homosexuality was removed from the DSM IV [Diagnostic and Statistical Medical Manual] as a mental illness. Although that meant technically I (and many others) had been cured overnight of a mental illness and our equal status recognised – the stigma remained.

What can communities and individuals do about it?

You can’t know what you don’t know, so until you have experienced exclusion for yourself, it’s hard to understand or imagine another’s experience of self-stigma. Each individual’s experiences are unique, very subjective and equally valid.

However, being aware of the social construction of disability [that is, people are disabled by social marginalisation rather than from any impairment] can help people to accept the concept of stigma, and be more sensitive to those affected by it. Just knowing that it exists can help us to be more sympathetic to someone else’s experience.

On the other hand, sensitivity and sympathy don’t make it go away. Frantz Fanon, trying to understand the nature of colonialism, concluded that oppressed people must dis-alienate themselves to achieve freedom. Just as gay men and lesbians have had to “come out of the closet” to embrace their freedom, people with experience of mental illness must do the same.

In short: We have to be aware of other people’s pain and how to avoid causing more and then “Get over it!”

Warren Lindberg has had many varied roles in his career. He started as a teacher in Otara, south Auckland, before working at the New Zealand AIDS Foundation. He became the first national manager of the Like Minds, Like Mine Project in 1999 (until 2001) and since then has been a Human Rights Commissioner, then Public Health Planner before taking up his current role in the Public Health Directorate.

By Dean Manley

What were the results?
Feedback on the *Like Minds* survey

Thank-you to those people who took the time to respond to the *Like Minds* newsletter survey sent out with the last issue. We enjoyed reading your feedback.

We had 55 responses to the survey. 17 respondents worked for *Like Minds* service providers and the remaining 38 were other types of readers.

Most respondents preferred to continue receiving the *Like Minds* newsletter in print (50) with the remaining respondents requesting email or internet options.

37 respondents said that they read the entire newsletter, 10 read three-quarters, four read half and one respondent read one-quarter of the newsletter.

48 respondents thought the LMLM newsletter kept them informed about the work of the *Like Minds* project and one respondent thought that it did not keep them informed.

Respondents rated each type of article in the newsletter.

- 21 enjoyed the feature articles and 2 didn't
- 27 enjoyed the regional news and 1 didn't
- 31 enjoyed the event reports
- 39 enjoyed articles on new initiatives and 1 didn't
- 21 enjoyed book reviews
- 30 enjoyed training and education information and 1 didn't
- 26 enjoyed people profiles and 1 didn't
- 20 enjoyed award information and 2 didn't

In order of most requested, respondents said what new features or additional information they would like to see in future issues of the *Like Minds* newsletter:

- 30 requested information about important contacts
- 27 requested information about upcoming events
- 23 requested more international features
- 23 requested more regional news
- 22 requested political issues
- 22 requested a soap box (opinion piece)

Other suggestions included:

- a list of agencies, who funds them and what they do with/for consumers
- tangata whaiora services and what they are doing
- resources available for service users (like documentaries, budget services and control advice)
- more about human rights perspectives on mental health
- personal and/or recovery stories from tangata whaiora
- Pacific Island and Asian profiles
- conferences of interest.

Respondents enjoyed the newsletter's positive approach and the profiles – those that were inspiring, those that celebrated the recovery journey and those about like people in like circumstances. They liked the up-to-date news and information about news initiatives and other services. They also thought the newsletter was easy to read and colourful.

One respondent thought the newsletter was too positive – in a way that did not reflect the reality of people's experiences with mental illness. Other negatives were old or repetitive news, articles that are too long and a feeling of alienation as everyone profiled in the newsletter has 'succeeded'. The small font size bothered one respondent as did the glossy paper and another respondent that the stories focused on the same 'faces' all the time.

36 of respondents thought the newsletter met the needs of people with experience of mental illness. 26 respondents thought it met the needs of friends and family. 43 thought it met the needs of *Like Mind* supporters and 35 the needs of mental health professionals.

Those who responded to how the *Like Minds* newsletter could be improved to meet the needs of Māori, Pacific Island and Asian people thought that having positive recovery stories, profiles, photos, workshop information and information about community-based initiatives from those ethnic groups would help to meet their needs. It was also important to make sure the newsletter was reaching people in those communities. Another suggestion was to use design and images for Māori, Pacific Island and Asian stories and greetings in the relevant language.

Some of your suggestions for improvements were:

- Accessible format options for the newsletter (Braille, large print, electronic).
- To make the newsletter bigger – with more stories, news and information.
- Better photos, some cartoons, jokes and slogans.
- More in-depth stories, more stories about personal successes and experiences.
- Information about recovery strategies and what community resources there are.
- Focus on some of the great things happening in the small groups around NZ.
- Best and worst moments in people's experiences with mental illness.
- A contacts or links page for consumers and consumer run services.
- Using the newsletter to let people know about petitions.
- Information on ongoing court cases about righting the past wrongs (institutional incarceration) and mental health and the justice system.
- More about consumers in employment.

Thank you for all your feedback and suggestions. We will let you know in future issues which ideas and changes we have been able to include to improve the newsletter and make it a better resource for all our readers.

NZ Mental Health Media Grants

Don’t forget that applications for the inaugural NZ Mental Health Media Grants close on 31 May, 2007.

The grants are open to applicants in one of two categories:

Category one: media professionals (print, radio and tv journalists, photo-journalists, freelance writers, documentary film makers).

Category two: creative media projects (artists, writers, musicians, community groups and those with an interest in mental health).

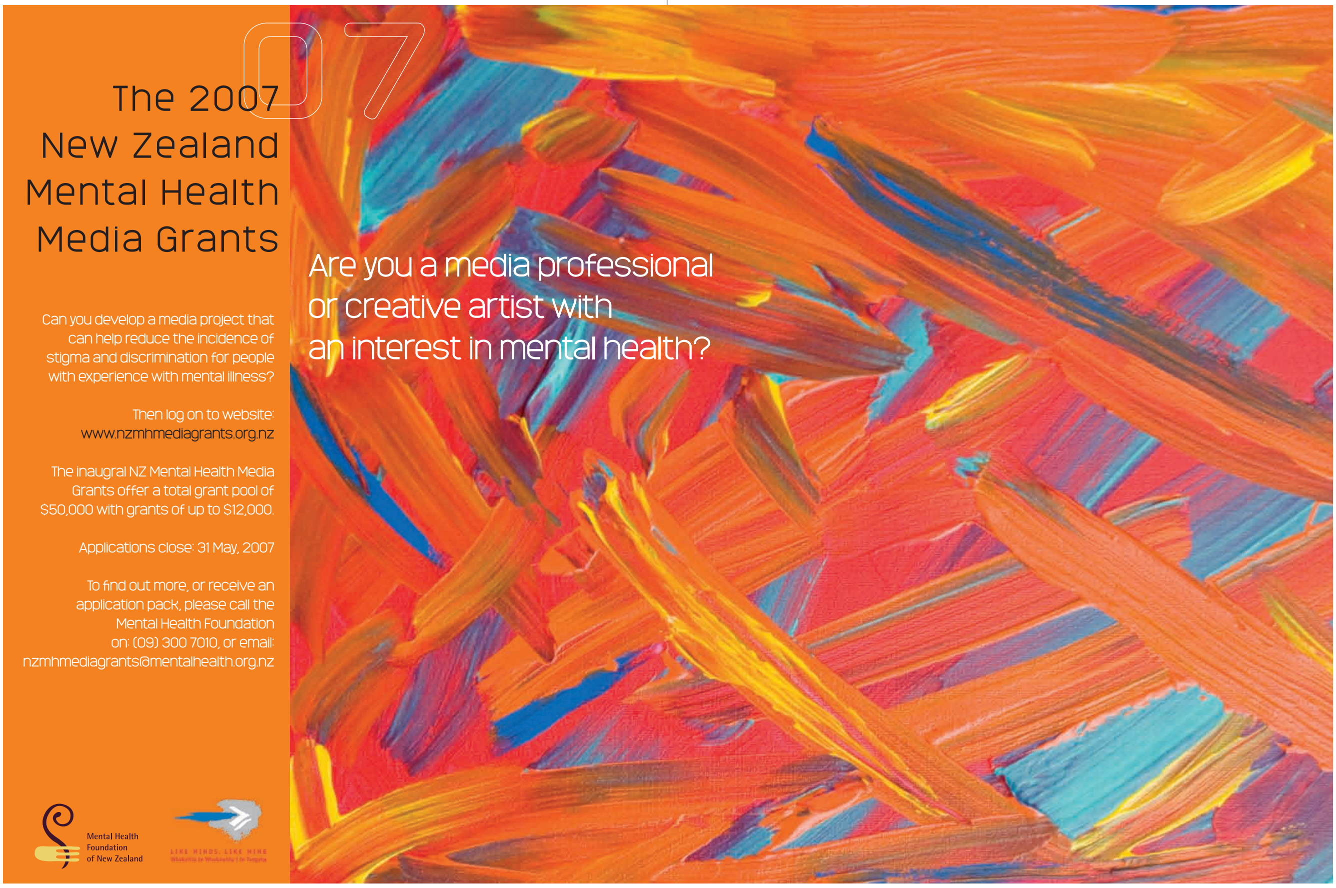
There has been a high degree of interest in the grants with the website recording more than 4000 hits and 590 individual visits over the two months since Grant applications opened.

We’ve added a links and a resources page to the site to help applicants find information that may be relevant to their application, so if you haven’t checked out the website yet – please go to www.mediagrants.org.nz for more information.

You can download an application pack from the website or email: infor@mediagrants.org.nz or phone: (09) 300 7010 to get a pack posted to you.

You are welcome to contact us with questions or concerns that you have. We look forward to receiving your applications!

Below: Postcard promoting the 2007 Mental Health Media Grants posted out to potential applicants.



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The 2007
New Zealand
Mental Health
Media Grants

Are you a media professional or creative artist with an interest in mental health?

Can you develop a media project that can help reduce the incidence of stigma and discrimination for people with experience with mental illness?

Then log on to website:
www.nzmhmediagrants.org.nz

The inaugral NZ Mental Health Media Grants offer a total grant pool of $50,000 with grants of up to $12,000.

Applications close: 31 May, 2007

To find out more, or receive an application pack, please call the Mental Health Foundation on: (09) 300 7010, or email:
nzmhmediagrants@mentalhealth.org.nz

Mental Health
Foundation
of New Zealand

WOULD YOU LIKE TO RECEIVE A COPY OF THIS NEWSLETTER?

Just complete this form, then mail or fax it to the address below and we’ll add your name to the mailing list.

NAME ______________________________

ADDRESS ______________________________

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Please tick: ☐ Update details ☐ New subscription

Shaughan Woodcock, Mental Health Foundation, PO Box 10051, Dominion Rd,
Auckland 1446 Ph: (09) 300 7010 Fax: (09) 300 7020

www.likeminds.org.nz

LIKE MINDS, LIKE MINE
Whakaitia te Whakawhiu i te Tangata

The project to counter stigma and discrimination associated with mental illness is an initiative of the Ministry of Health.

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