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Narratives and health: Fostering prosocial communities among recent immigrants to Toronto

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In Forrest Tyler's recent book, *Developing prosocial communities across cultures*, he recalls two experiences that he and his wife, Sandy, had in Colombia and India that illustrate the idea of prosocial communities and a key claim of this paper, which is the importance of listening to people's own voices as they recount their strengths and their challenges. In the first, Forrest recalls the experience he and Sandy had in Colombia when they were asked to document the experience of Colombian street children in the children's own words. These children were generally despised and marginalized. However, when asked to tell their stories, they told of a sense of themselves and their communities as being resourceful and of having strengths as a community. This was different than what the experts expected. As the Tylers experienced, "the experts viewpoints reflected only their own, discipline limited outlooks about the nature and capabilities of these children" (Tyler, 2007, p. 2).

A few years later, in the second account, the Tylers were in India on a Fulbright Fellowship. Sandy sought to work on issues of domestic violence, but was discouraged by the upper caste women Indian psychology professors who did not see the lower caste women as suitable to work with. When Sandy persisted, she found that the lower caste women were quite aware of the problems of domestic violence and had a good handle on its contingencies and what they may be able to do about it. Again, the voices of those usually marginalized are important to hear if we want to develop prosocial communities.

In our study, *Narratives and Health: Building on Cultural Strengths of recent immigrants to Improve Health Care*, we deliberately sought to hear the voices of these newcomers to Toronto, so that they would be empowered and we would have a better grasp of how to work with them to improve their chances of receiving good health care.

Canada has near-universal health care for its citizens, permanent residents, asylum seekers, and refugees. Although the system varies by province, basic health care is everyone's right, at least by law. In practice it does not always work out equitably for everyone. That is, health care is not necessarily a part of the pro-social framework. Let me give an example. Canada has a population of just over 30 million, with most of that population in Toronto, Montreal, and Vancouver and almost all the rest within a couple of hundred miles of the United States border. Of that 30 plus million, 5 million persons do not have a primary care physician. This problem is particularly acute in Toronto, Canada's largest city. There are complex reasons for this, but one is that the provincial government actively discouraged the expansion of medical schools and the settling of physicians

in the Greater Toronto Area (GTA) in the 1990s. Another is that almost insurmountable barriers are in place for physicians who immigrate to Canada, with incredible demands placed on them for re-licensure and punitive restrictions on them for place of practice. An immigrant physician who manages to overcome the paperwork barrier has to agree to practice in the least settled areas of Ontario for five years after getting a license—however, there is an inadequate population to support a doctor's practice in these areas.

This is not a prosocial community in action but a profession protecting its turf. Much the same situation exists for psychologists who immigrate, except from the United States or England. Combine that statistic, 5 million persons without a physician, with the immigration statistics, about 300,000 persons a year coming to Canada, mostly to Toronto, Montreal, and Vancouver, and you soon see that the persons most likely to be without a physician are recent immigrants. Compounding this is that many of the immigrants since the 1960s and overwhelmingly since the 1990s are persons of color, immigrants from East Asia, South Asia, and Africa. This is the context for our work.

Project Description and Rationale

Our community-based exploratory research was designed to describe, understand and emphasize the strengths inherent in cultural health beliefs and practices of recent immigrants. In this study, we used the definition of health developed by the World Health Organization: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

As part of a pilot study, we used narrative interviews to explore the perception and understanding of health beliefs and practices of 20 recent immigrants,10 from a local community center for immigrants in downtown Toronto and 10 immigrant university students. Our intention was to focus on cultural strengths. We employed a conception of culture that assumes it is dynamic, fluid, and emergent, rather than a static and fixed entity (Dorazio-Migliore, Migliore, & Anderson, 2005; Hermans & Kempen, 1998).

Our questions were the following: How do immigrants express their understanding of health, illness and their need for health care? How do they relate their understanding to the dominant model of health beliefs and practices found in Canada? What are the cultural strengths related to health that immigrants bring with them? How can these strengths be used to facilitate the transition to a new country and improve access to health care and, potentially, improve the delivery of health care services?

Immigration is typically a stressful experience, even when individuals or families have ample resources. Most immigrants, of course, do not have such resources and many come to their destination knowing only a few people, or perhaps, no one at all. Immigration is stressful, in part, because of the resultant loss of social support and inadequate financial resources. In many cases, there is a change in profession, often to a lower-paying, lower-status, job (Salaff & Greve, 2003). (There is a wry joke in Toronto that we have the world's best educated taxi drivers!) In addition, there is often a disruption to family life and prior family roles (Ahmad et al, 2004; Dossa, 2002; Suarez-Orozco, C. & Suarez-Orozco, M. 2001; Suarez-Orozco, Todorova, & Louie, 2002). The acculturation process that attends immigration is often stressful, "which manifests itself in health problems" (Kirkcaldy et al, 2005, pp., 296; Simich, Hamilton, & Baya, 2006). Due to the overall poorer health experienced post-migration (Simich et al, 2006), there is an even greater need to increase immigrants' access to healthcare. Health care, both access and utilization, is a major issue with immigrant, especially recent immigrant, populations both in Canada and in every major immigration destination (e.g, Groleau & Kirmayer, 2004).A significant body of research indicates that immigrants and members of non-majority populations encounter significant barriers to health care, even when there is universal health care (e.g., Ismail et al, 2005). Recent immigrants are often at a serious disadvantage in their encounters with health-care providers, as providers often fail to understand the cultural context, including health beliefs and practices,

of recent immigrants (e.g., Chan et al, 2006; Yeo et al, 2005). This frequently leads to underutilization of health care resources and the under representation of immigrants in health care research (Chun & Chesla, 2004; Groleau & Kirmayer, 2004). The latter may be particularly problematic in the development of appropriate diagnoses and delivery of culturally appropriate services (Sue, 1998). Evidence also indicates that immigration may be particularly problematic for women's health (Dossa, 2002; George & Rail, 2005).

Many immigrants continue to use health care approaches rooted in their home culture, even after several years in the new host country (Ahmad et al, 2004; Chappell & Lai, 1998; Chan et al, 2005; Yeo et al, 2005). Yet, they also use care grounded in biomedicine (Groleau & Kirmayer, 2004). In some cases, this may represent a threat to their health status due to interaction effects. In other cases, the reliance on more traditional approaches may be adaptive and helpful (Chun et al, 2004; Goodman, 2004). However, many health care providers trained in the biomedical approach remain dismissive of such traditional health beliefs and practices. As a result, unnecessary barriers to health care may be erected for immigrants who are rightfully discouraged from revealing their practices or even using the available health care services (Yeo et al, 2005). One intention of our research program is to help reduce the misunderstanding and barriers to health care for both providers and immigrant recipients.

Cultural Strengths

As serious and important as the problems related to health are for immigrants, little attention has been paid to the resources or cultural strengths that immigrants bring with them. Human beings are resilient, even in the face of traumatic experiences (Masten, Obradovic, & Burt, 2006). Without minimizing the negative impact of such experiences, it is possible to go beyond them and to seek to understand the core strengths of immigrants. It is our contention that these strengths lie in the cultural foundations of people's lives.

Strengths-based approaches have been developed in social work (e.g. Saleebey, 1996) and in some areas of American psychology (e.g., Seligman, Rashid, & Parks, 2006). Tyler's work on prosocial communities has been an important positive development within psychology for many years (Tyler, 2007). The need to focus on strengths has been particularly stressed in mental health work with racial and ethnic minorities in the United States, an emphasis that began with the Black Nationalist movement in psychology in the late 1960s (Carlton-LaNey, 2003; Stevenson & Renard, 1993; White, 1972). The longstanding work of the late psychologist, Emory Cowen, and his students at the University of Rochester on prevention and wellness has had an enduring impact on community psychology (Cowen, 2000). Psychological research on resilience has also been oriented toward human strengths in dealing with adversity (Grotberg, H. E., 2003) or trauma (Saul, 2003). Yet, little has been written about cultural strengths as resources for immigrants.

Narratives

Anthropologists and, increasingly, psychologists argue that storytelling may be universal among humans and may form the foundation of how human beings understand themselves and the world (Bruner, 1990; McAdams, 1993). Evidence is emerging that indicates that narrative may be the most useful approach to discover cultural strengths and the human resilience that flows from those strengths (Dossa, 2002; McAdams, 1993; Skultans, 2000). Within the large and growing body of qualitative research with immigrant populations, the use of narratives has emerged as a successful approach. The narrative format allows individuals to tell their stories in ways that are close to their lived experiences (Chan et al, 2006; Dossa, 2002; Groleau & Kirmayer, 2004; Ismail et al, 2005). Narrative is a particularly effective methodology for interpreting the experiences and health beliefs of marginalized peoples, including immigrants, specifically because it does not disengage the speaker from important contextual and linguistic factors (Skultans, 2000; Tashiro, 2006). We sought in our study to give voice to the immigrant narrative, which is not well-represented in the Western meta-narrative seen

in Western cultural media, such as television or film.

Explanations of health and illness are grounded in a dynamic cultural matrix, as, one could argue, all such health beliefs must be (Dorazio-Migliore, Migliore, & Anderson, 2005; Greenhalgh, Collard, & Begum, 2005). When told in their own language, especially, immigrants' stories provide a rich resource for understanding the role of cultural beliefs and cultural strengths in health and illness. These stories help depathologize the immigrant experience, while helping immigrant communities make sense of their experiences (McAdams, 1993). The potential, then, of using narratives is that not only will such stories reveal problematic aspects of the immigrant experience, but they will also reveal the strengths that immigrants bring, which can then facilitate positive health outcomes (Greenhalgh, Helman, & Chowdhury, 1998).

Participants and Methods

The research team is comprised of one university professor and 8 students. A variety of languages and immigrant statuses are represented in the research group, giving us a unique perspective on the immigrant experiences that are the object of our research.

The narratives collected in this study were created in an open oral history interview format. Oral histories are a window into lives and the cultures where those lives are lived. As one author phrased it, "It is very often when narratives are most personal that they draw upon the deep structures of the cultures to which they belong ..." (Skultans, 2000, p. 11).

Participants. We recruited 20 participants for the first phase of our study. [There are actually 12 other participants—all Iranian—that we did not include in this report due to the slow pace of translating and transcribing from Farsi.] These 20 participants were drawn from two different settings. First, we recruited 10 participants from a well-known immigrant community resource center in downtown Toronto. The length of time in Canada ranged from 3 months to 12 years. The age range of this group was 24-46, half of them were married. Countries of origin included countries of East Asia, South Asia, South America, and sub-Saharan Africa. Where appropriate, interviews were conducted in the language of the participant, with a translator present. Because we considered that age differences may prove important, for example, younger people may be more inclined to use Western medicine, we also recruited 10 students from a local university. The age range was 18-28 and one of the students was married. A variety of countries were represented; in addition to the regions noted above, there were also students from the Middle East. The duration of each interview was from 40 minutes to an hour and fifteen minutes. Surveys were utilized in order to acquire demographic data such as age, country of origin and other to supplement the findings and background information.

Analyses. We anticipated that the oral histories will be rich in thematic material, as themes seem to occur "naturally" in stories (e.g. Tashiro, 2006). We also anticipated that many of these naturally occurring themes will be core to the person's identity, that is, they will be epitomizing narratives (Dossa, 2002).

We coded and analyzed the transcripts manually in order to identify common themes. We used manual coding, rather than using a software designed for this, in order to avoid omissions, restrictive categorizations, or other errors. We established a 70 per cent interrater reliability as an acceptable level.

Results

Access & Utilization: Our results were in agreement with other findings that health care, both access and utilization, is a major issue with recent immigrant populations in Canada. We found that recent immigrants were likely to underutilize health care. Our results indicated that many immigrants continue to use health care approaches rooted in their home culture, even after several years in Canada. Yet, they also use biomedical care. One common theme was the immigrants' experience that many health care providers trained in the biomedical approach were dismissive of traditional health beliefs and practices. Our participants, too,

reported that the attitudes of health care providers often discouraged them from using their services except in emergencies. Several participants indicated that they would only use the Canadian health care system as a provider of last resort, as they were so disheartened.

A common complaint was the wait time for medical care. Most of our participants have not been able to find a primary care physician. As a result, hospital emergency rooms and walk- in clinics are the options used when seeking health care. Our participants reported wait times ranging from one hour to 18 hours. These wait times were often compounded by impersonal care when the patient was seen. As a result, many of our participants reported very low satisfaction with the health care system.

Cultural Strengths. But, what about our participants cultural strengths, those resources located in their culture of origin that potentially could help them as immigrants in their new country? The results were mixed on this. First, all but one of our participants reported that in their country of origin they learned health practices grounded in the local culture. Themes that have emerged so far include reliance on special foods, herbs, or drinks (e.g., teas) as important for restoring and maintaining health. While the particular food or drink varied from culture to culture, it is clear that conceptions of health in many cultures center on eating and drinking the right things. (There were many complaints as well that Western food, McDonald's was mentioned most frequently, was ruining the health of the home population.) Most, but not all, our participants especially relied on traditional home remedies for minor complaints. There was a great deal of variability here, as one of our participants reported strong belief in the power of the evil eye and the power of an enemy to inflict illness through manipulation of the spirit world. For such illness, special teas and foods were important to the remedy, but the key action was to seek the help of a local healer to reverse the spiritual manipulation.

Experiencing nature through an activity was also a common theme of what it means to be healthy for many of our participants. This could mean rising early to breathe fresh air or hiking through a park or just being outdoors.

Cross-generational knowledge transmission of health maintenance was also important.

Many of our participants reported a family member: mother, grandmother, occasionally a grandfather, who told them how to care for themselves. Often, it was a particularly close relationship, e.g., a grandmother, that sensitized the participant to self-care.

All of our participants also reported that they relied on allopathic health care, the biomedical model. All of them utilized visits to health care providers with some regularity, but especially for serious health concerns. Most, but not all, reported that when they had a personal primary care physician in their home country, it was typically a close relationship. The physician could be counted on to listen to complaints patiently and to provide guidance for many of the affairs of life.

Finally, and this helps us return to the main topic of our symposium, prosocial communities, many of our participants reported that when they were in their culture of origin, they were embedded in a rich matrix of relationships that informally guided them toward healthy beliefs and actions. That is, they were living in prosocial communities. Just so this does not seem pollyannish, a number of our participants had immigrated or become refugees because of strife in their home country. Their sense of community back home had been destroyed.

One way to interpret our tentative findings is within a prosocial framework. Many of our participants left homes and communities where they felt they had belonged and where they were part of longstanding kinship and friendship networks. They left, many of them, because they wanted a better education and more opportunities for their children, or for economic reasons, and a few left because of political reasons. What they have found so far in Toronto is a struggle to regain that sense of belonging and of being in a place where they are cared for and can adequately care for their loved ones. We

believe from what our participants have told us that they brought with them resources that can help them do so. What we hope to do is elucidate their strengths in ways that will help the host culture be receptive to those strengths.

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