

A critical examination of how barriers in communicating can lead to social exclusion.

This assignment critically examines how barriers in communication can leave disadvantaged individuals further excluded in society. The case study which will be critiqued will be black and minority ethnic (BME) individuals with mental illnesses facing cultural barriers with seeking help (Brighton and Sussex Medical School, 2016). The essay will discuss how their own cultural norms in medicine influence when and how they access treatment (Nieuwsma *et al.*, 2011), and how they may not share the same view towards psychiatric treatments (Link and Phelan, 2001). Furthermore, stigmatization of mental health within their culture will also be examined, as well as stigmatisation in mental health on whole (Link & Phelan, 2001; Pescosolido *et al.*, 1999). Additionally, discussing how mental health diagnoses can bring implications, along with policies, practices and services aimed to improve user experience (Rosenfield, 1997).

Firstly, to define mental illness. Mental ill health is behaviour that individuals develop which may impact on their everyday living, and this often stems from their individual genetics, biological attributes, or neurodevelopmental issues (Strathdee, 2015). An alternative to this concept is Horwitz (2002 cited in Scheid & Brown, 2010), who suggests that the term mental illness defines conditions that society uses to label certain behaviours, and that social perspectives influence the definition and response to mental health problems. On top of this, differing views should be considered of what is healthy and sick, normal and abnormal, and what is dependent on the sociographic of an individual (Scheid & Brown, 2010). As Jirojwong and Manderson (2001) highlighted, illness and health are not set to one culture but are culturally constructed. Furthermore, individuals also judge on the basis of their own cultural norms and think less of others for not adhering to these norms, this perspective is labelled ethnocentrism and can also be viewed as a form of racism (Carignan *et al.*, 2005; Brislin, 1990). In addition, individuals can receive further labelling in diagnosis of their individual conditions, and although it can validate what course of treatment is required, it can also cause further anxieties in individuals along with stigmatisation of officially holding an illness (Vos, Roberts & Davies, 2019; Rosenfield, 1997). As in comparison to western society, mental illness in Asia is considered shameful and socially disapproved by Asian society (Lauber & Rossler, 2006). Link and Phelan (2001) define this form of stigmatisation as ‘cultural conceptions of mental illness’ or ‘dominant cultural beliefs’. However, the stigmatisation is usually negative with individuals perceived as dangerous, unpredictable, and hard to engage with many individuals distancing themselves from the individual and the family (Pescosolido *et al.*, 1999; Lauber & Rossler,

2006). For instance, due to mental illness being perceived as a family issue, it can impact economic resources and marriage prospects for other members of the unit (Lin & Cheung, 1999).

This may possibly be because Asia is more traditional to its culture, in comparison to western civilisation, and has religion heavily embedded into causes of illness and treatments (Sheikh and Furnham, 2000). This can be seen by the high following of Buddhism, where self-control, emotional restraint, and social inhibition are taught from childhood, but also where mental illnesses are perceived as shameful (McCarty *et al.*, 1999). Nevertheless, the understanding of these cultural differences has not been able to move medical treatment away from the ethnocentric paradigm (Manderson & Mathews, 1985). Although, individuals who have a high level of education and live more urbanised have better understanding than villagers and those living more traditional lifestyles (Wyaden *et al.*, 2005).

Furthermore, variations in health practices along with alternative medicine are prevalent throughout different cultures worldwide, with non-orthodox medicine being the societal norm in low- and middle-income countries (Gureje *et al.*, 2015; Nungesser & Bierman-Mulvey, 2003). Additionally, barriers to treatment also influence alternative therapies within Asia, such as location of services along with unprofessional stigmatising behaviours from the practitioner (Lauber & Rossler, 2006). It can be seen that individuals that seek to use alternative therapies do so through individual belief and value, rather than being dissatisfied with conventional medicine (Austin, 1998). Furthermore, a study found Asian communities living in Australia favoured treatment from their own cultural network, rather than statutory health and welfare services (Wynaden *et al.*, 2005). Another way in which culture has an effect on mental illness is how patients describe symptoms to their general practitioner (GP) (Satcher, 2001). For instance, Lin & Cheung (1999) found patients of Asian background appear to report their physical symptoms above their emotional ones, however, when further asked, it was found that they also possessed the emotional symptoms. This evidence also backs Kleinman's (1988) view of individuals in different cultures only acknowledging certain symptoms that follow their cultural norms. Although other ethnicities face mental health issues, BME groups were noted to underutilize the help of mental health services and terminate treatment early (U.S. Department of Health and Human Services, 2001). Opinions towards mental illness do tend to fluctuate dependent on the individual's beliefs, ethnicities, cultures, or their country's attitudes influencing their social views (Nieuwsma *et al.*, 2011).

Continuing with stigmatisation, Hall (2000) found identities given to individuals are usually given by society which have a historical connection to them, and are constructed from individual social views. This is exemplified by Fryer (1984) stating how racial stereotyping within the UK can be seen to originate from the country's involvement during slavery and colonial ruling. Although the UK has an issue with mental health stigmatisation, it can be seen internationally that there is no noted society or culture where individuals with mental illness are treated the same as those without an illness (Rossler, 2016). It must also be highlighted that not all individuals within a certain culture follow dominant cultural beliefs about stigma and form their own views, although they are aware of others' views (Corrigan & Watson, 2002; Bracke *et al.*, 2019). However, research by Brack *et al.* (2019) on whether cultural stigmatisation influences individuals accessing mental health services, found that overall beliefs of an individual's country do in fact impact the majority of attitudes of its citizens accessing support, regardless of their own views.

This also further highlights that stigmatisation comes in two forms- self-stigmatisation and public stigmatisation (Haddad & Haddad, 2015). Arboleda-Flórez and Sartorius (2010) similarly noted a minority of individuals fail to seek help with their mental health problems due to the stigma, prejudice, and fear of social exclusion connected to them, even if they do not share similar beliefs (Nearchou *et al.*, 2018). However, individual self-stigmatisation must also be considered as some individuals may not be influenced to stigmatise and do so on their own accord, and as a result this can impact their likelihood of asking for help, causing a barrier to seeking early intervention and support from mental health services (Vogel *et al.*, 2007). Additionally, this failure to seek early help then often escalates as the individual waits until their symptoms have become more serious (Parle, 2012). The term self-discrimination/self-stigmatisation is when individuals with mental health issues develop attitudes towards themselves based on a public conception of mental health, although intervention is more successful at the beginning of symptoms, it can also prevent further deterioration of mental illnesses, allowing individuals to maintain employment, relationships, or social standing (Parle, 2012). Corrigan (2004) found that stigma not only affects individuals' self-esteem, it also impacts their amount of social opportunities. Rosenfield (1997) similarly found that labelling individuals can impact their employability, relationships, and community care. This can be seen by the HSCIC's (2013) findings that individuals with more severe mental illnesses in employment was recorded to be 7.3%, the lowest figure for all disability categories. Therefore, it is evident that individuals with mental health problems, or physical disabilities, encounter

barriers to employment along with stigmatization from employers (Cummins, 2016). Disability was described as a state of disadvantage which impacts individuals socially, politically, and cause material disadvantage which is socially constructed (Seymour & Lupton, 2000). Through stigmatisation and labelling individuals can become more disadvantaged developing further mental illnesses alongside prolonging their current one (Gaebel, Rossler & Sartorius, 2017). The reasons why individuals stigmatise have however been highlighted in a few studies, and it is believed to come from their lack of knowledge of mental illnesses (Parle, 2012). As a result, many individuals still believe those with schizophrenia have a split personality, and it appears they are also not aware of the difference between a learning difference and mental illness, along with the idea that is held about those with depression, that they can ‘snap out of it’ (Thornicroft, 2006).

Although, it appears that attitudes and stigmatization of those with mental illness are improving, and this may be due to societal attitudes that are changing because of education via public campaigns and programmes (Gaebel, Rossler & Sartorius, 2017). It can be seen that the stigma around mental illness still impacts the delivery of effective services for improving mental health, impacting the quality of care, access to services, and policy (Arboleda-Flórez & Sartorius, 2010). This was highlighted by The Mental Health Foundation (2016) who found that health research funding only contributes 5.5% to mental health in the UK. This figure reflects within austerity policies on the delivery of mental health services, further disadvantaging individuals who require social support the most, such as those with more severe mental health disorders who receive unemployment benefits (Cummins, 2018; Centre for Mental Health, 2013). Spicker (2011) implied that policies aimed at individuals with mental illness, who are stigmatised, aim to reintegrate them back to the community, and this is achieved through promoting independence and hopefully changing public attitudes towards mental illnesses. Subsequently, it is an illegal offence under the *Equality Act 2010* to discriminate against individuals directly or indirectly due to their health status within access to services and treatment, access to premises, employment, education, and transport.

Further protection of vulnerable individuals is included in Acts such as *The Community Care Act 1990*, the *Social Services and Wellbeing Act 2014*, the *Mental Health Act 1983*, the *Mental Capacity Act 2005*, *Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards*. These Acts and policies ensure individuals are receiving appropriate access to services and are considered to hold the capacity to make decisions unless it is in their best interests to make

decisions on their behalf. Additionally, under the *Social Services and Wellbeing Act 2014*, the *Mental Health Act 1983*, the *Mental Capacity Act 2005* and *Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards*, all assessments must ensure that individuals with mental health concerns can receive a mental health advocate to inform individuals of their rights and participate in decisions which involve them, along with an interpreter if there is a language barrier. Another point to add, is that individuals may possess communication problems due to their illness, or lack the capacity to instruct, and require support with making decisions based on their beliefs (Welsh Government, 2011).

Likewise, language is a major factor of considering mental illness stigmatisation, from appropriate use of medical terms to speaking in person first terms, such as the person appears to have schizophrenia rather than labelling them as schizophrenic (Corrigan, Roe & Tsang, 2011). For instance, Vojak (2009) claims that professional terminology used to discuss individuals, their circumstances, and third sector services can cause stigmatisation and create inequality. Furthermore, change cannot be achieved in language until individual influences on appropriate terminology is successful (Corrigan, Roe & Tsang, 2011). It can be seen that there is a clear link between language and power, from the way individuals identify themselves socially and individually, although language can be used successfully to empower and liberate, there is also the negative impact it can cause, creating issues, discrimination, and distress (Thompson, 2011). An example of this is social workers that fail to recognise individual differences, rather than acknowledging them, creating barriers within their communication and practice (Poulin & Matis, 2019). Furthermore, practitioners that fail to acknowledge differences and view the client as intimidating based on their differences, stereotype their client along with oppressing them further (Poulin & Matis, 2019). This however could be perceived as racist as its basis alone is not just on attitudes and beliefs, it also applies to individuals' behaviour, practice, and actions (Carignan *et al.*, 2005).

Although Reichert (2011) acknowledges cultural relativism by acceptance of different views and opinions, considerations on human rights must also be considered as some practice may be viewed as inhumane or outdated. Practitioners can however improve interpersonal skills in diversity by possessing multicultural understanding, holding knowledge on non-traditional health beliefs, offering culturally appropriate services, and personal plans which reflect the individual's cultural beliefs (Nungesser & Bierman-Mulvey, 2003). Cultural competence however is a multidimensional concept with a variation of interpretations on what it consists of and how it should be materialized (Chun & Takanishi, 2009). This concept can be most

frequently defined as ‘holding consistent behaviours, attitudes and policies which promote individuals and organisations to work within a multicultural way successfully’ (National Health and Medical Research Council, 2006; Cross *et al.*, 1989). Despite this awareness of cultural competence, training on communication skills will not necessarily improve cultural competence (Fredericks, 2008; Saha *et al.*, 2010).

Globally there has been an increase in immigration which has broadened linguistics used and widened cultural diversity internationally, and this has led to an increased public use of interpreters across public service settings (Elkington & Talbot, 2015). Inclusion in interpretation not only promotes a person-centred agenda it can improve client satisfaction, improving client contribution to their treatment, as well as appropriate medication use (Moore *et al.*, 2017; Smith & Claire, 2008). This could be due to the interpreter being fluent in both languages, improving communication in both client and practitioner (Smith & Claire, 2008). Although rare, another point to add is interpreters do not always translate successfully as words can have differing meanings in different societies (Drugan, 2017; Mandelstam, 1999). However, some services may not have access to translators and may use multilingual staff members to do the role of a translator, increasing the chance of error in diagnosis and care received (Hagan *et al.*, 2013; Tribe & Tunariu, 2009). Moreover, according to Hadziabdic *et al.* (2013), family members being used as interpreters can cause further issues, including confidentiality and privacy issues where clients may not want to share information. Also, they may incorrectly translate for their benefit, along with finding it emotionally distressful to communicate difficult news (Hadziabdic *et al.*, 2013).

On top of cultural needs, social workers and other practitioners should be following ethical practices whilst working with vulnerable clients, and as Smale (2000) implied, practitioners should be preventing social exclusion whilst identifying clients’ needs. Ethical practice guidance is also available publicly, making both client and practitioner aware that practitioners should be including the clients fully in a manner which can enable and empower them on issues surrounding their circumstances (BASW, 2014). Another point to add is that practitioners must also acknowledge the vulnerability of their clients and offer choices, as failing to do so leads to individual assumptions of the client’s choice. Additionally, nonverbal communication can negatively impact individuals, such as nods, grunts and gestures can influence an individual to take a certain outcome (Sheppard, 2006). Moss (2012) noted high standards of practice cannot be attained unless practitioners possess a similar high standard of communication. Therefore, practitioners should be encouraging client participation applying suitable vocabulary that

clients are able to grasp and understand (Petriwskyj, Gibson & Webby, 2014). Although effective conversation does benefit client participation, Datar *et al.* (2008) suggested listening to clients' needs, alongside giving them adequate time to speak about their concerns is equally as important.

To conclude, this essay has critically examined the case study of BME individuals seeking help with mental illness, and the cultural barriers they face (Brighton & Sussex Medical School, 2016). Firstly, it can be seen that there are two differing views on contributors of mental health, one being a genetic issue caused by hormone imbalances or hereditary factors, secondly it being a result of our environment (Strathdee, 2015; Horwitz, 2002). Next it was highlighted that diagnosis causes issues, firstly that many individuals felt ashamed and preferred to seek alternative therapies (Nieuwsma *et al.*, 2011; Austin, 1998). This was due to the cultural stigma linked to mental health, which left many individuals seeking treatment when their symptoms had advanced. Furthermore, they also faced difficulties describing their issues noting the physical more than the emotional elements (Link & Phelan, 2001; Satcher, 2001). This link to cultural shame regarding mental health may be why BME groups underutilise mental health services (US Department of Health and Human Services, 2001). As the stigmatisation not only impacts the individual, but can also have an adverse effect on family members, economically, and possibly impact marriage for other members (Lin & Cheung, 1999). Stigmatisation was also found to be a result of historical cultures (Hall, 2000). However, stigmatisation of individuals with mental illnesses was found to be a global issue (Rossler, 2016). Although, within the UK Acts including the *Community Care Act 1990*, the *Social Services and Wellbeing Act 2014*, the *Mental Health Act 1983*, the *Mental Capacity Act 2005*, *Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards*, are in place to safeguard individuals and to ensure they receive appropriate care and services. This can be achieved through advocacy support, the use of interpreters, and through practitioners acknowledging cultural differences (*Social Services and Wellbeing Act 2014; Mental Health Act 1983; Mental Capacity Act 2005; Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards*; Moore *et al.*, 2017; Smith & Claire, 2008). Practitioners need to possess a multicultural understanding of their clients, and of non-traditional health beliefs that clients might follow, as well as offer personal plans that adhere to the clients' beliefs (Nungesser & Bierman-Mulvey, 2003).

(2946 words)

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