



Race, Culture & Counselling



Culture & Mental Health

- What is culture?
- Does culture matter in mental health intervention (and healing)?
- What might it mean for us to approach mental health from a culturally sensitive lens?
- Do different societies draw the same line between wellbeing and distress?
- How much training (as well as anxieties) do you have working with issues related to cultural relevance with different groups?



Culture & Mental Health

- How do we know that our constructs around mental health mean the same thing to service users?
- What adaptations are necessary to make sure interventions are effective?
- How will each of us take responsibility for upholding an ethic of cultural relevance and critical thinking as we discuss the multiple dimensions of what is known about mental health as well as the populations we represent and work with?

Culture & Mental Health

According to WHO, mental health is "defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

What is the role of *culture* in achieving an optimal state of health and wellbeing?





Culture & Mental Health

“The discourse on ‘culture’ that is applicable to mental health mainly concerns the culture of the individual because of the emphasis on the individual in the (western) interpretation of ‘mental health’...But even here it is recognized that individual culture rests on a bed of traditional family culture, the culture of the community they are part of, the wider body of people they felt attached to, the regions(s) they live in and even perhaps the ‘imagined communities’ (Anderson, 1991, title page) they are connected to. These ramifications of culture determine to a large extent people’s behaviour, and more generally, their social systems, religious systems and beliefs, worldviews and, most important of all...their concept of the human condition, the meaning of life itself” (Fernando, 2014, p. 13).



Culture & Mental Health

“[i]t is a process by which ordinary activities acquire emotional and moral meaning for participants. Cultural processes include the embodiment of meaning in habitus and physiological reactions, the understanding of what is at stake in particular situations, the development of interpersonal connections, religious practices, and the cultivation of collective and individual identity. Culture is inextricably caught up with economic, political, psychological, and biologic conditions. Treating culture as a fixed variable seriously impedes our ability to understand and respond” (Kleinman, 2004 as cited in Cromby, Harper, & Reavey, 2013, p. 57).

Ecological Systems Theory

E.g. culture & sub-cultures within macrosystems and microsystems

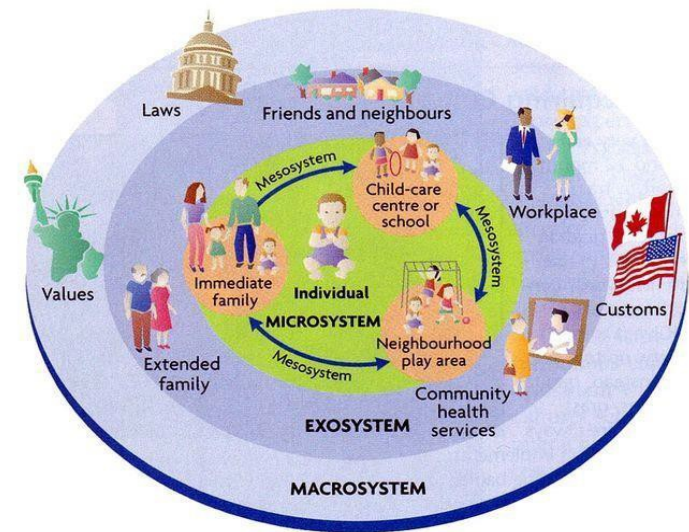


Figure 1. Bronfenbrenner's ecological systems theory
(in Berk & Roberts, 2009, p.28)



Culture & Mental Health – What's the relationship?

- Culture influences definition of mental illness
- Culture explains the cause of mental illness
- Cultural beliefs guide our reasoning regarding how we should address mental health problems
- Culture influences motivation to seek help and also impacts how mental illness is experienced
- Culture accounts for variation in how clients communicate their symptoms and which one they report
- Culture influences expectation between the clinician and service users (different assumptions about what a clinician is supposed to do, how a service user should act and what treatments are available)



Culture & Mental Health – What's the relationship?

- Culture influences what type of coping styles and social supports people have
- Culture influences the meanings that people impart to their illness
- Culture dictates how much stigma is attached to an illness
- Culture relates to how people cope with everyday problems and types of adversity
- Some aspects of culture also underlie culture-bound syndromes (sets of symptoms much more common in some cultural communities than others).

Culturally Competent Practitioners

Cultural competence: the ability to understand, communicate with, and effectively interact with people across cultures.

Cultural competence is our capacity to:

Be aware of our own worldview

Develop positive attitudes towards cultural differences

Gain knowledge of different cultural practices and worldviews

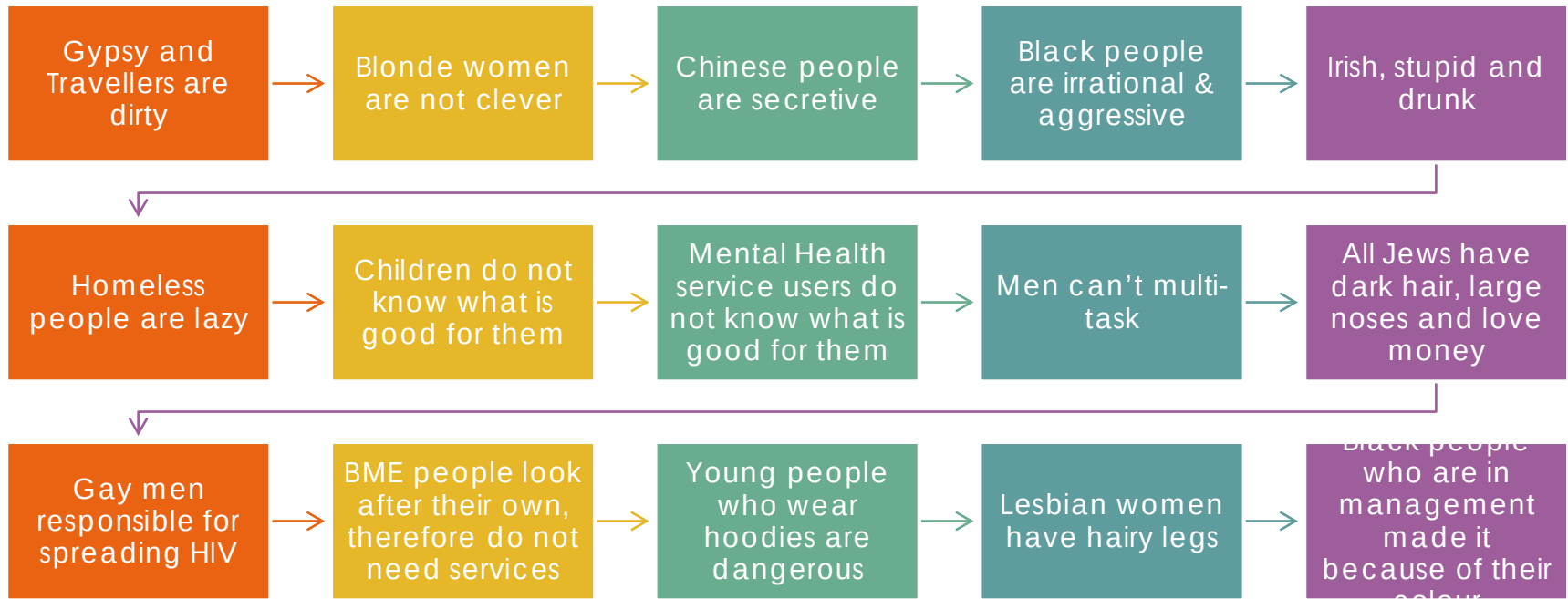
Develop skills for communication and interaction across different cultures



Task : Divide yourself into small groups and discuss these four questions:

1. What are the common stereotypes of Black people, White people and Asian people?
2. List other marginalised groups who were subjected to systematic forms of discrimination and abuse.
3. What are the common stereotypes of marginalised people (e.g. gay men, lesbians, young people, gypsies).
4. What do the stereotypes tell you about the underlying beliefs in relation to each marginalised groups?

Examples of some common stereotypes





“Especially the African Caribbean males on the ward, they do feel the vibes. They feel that people are shrinking away from them if they are trying to express themselves. What they see as expressing themselves, others perceive as sort of anger and almost threatened violence.”(quoted in McLean et al. 2003)

In a study comparing black and white patients, black patients were perceived as being more dangerous, despite exhibiting lower levels of aggressive behaviour (Bhui, 2001).

Black African suspects are more likely than white suspects to be arrested, tried by courts and six times more likely to be in prison and be given longer sentences (The Parekh Report, 2002).

Should BAME be ditched as a term for black, Asian and minority ethnic people?

By Rajdeep Sandhu
Political reporter

17 May 2018



GETTY IMAGES

BME women remain marginalised within current policy debates. They are often viewed exclusively, in stereotyped ethnic images – for instance, as ‘loud and difficult to manage’ in the case of African-Caribbean women, or in the case of Asian women, as having problems that are rooted exclusively in ‘cultural conflict or practice’ within the family. This results in their needs as women being ignored and overlooked (Keating, Robertson & Kotecha, 2003).

<https://www.bbc.co.uk/news/uk-politics-43831279>

Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England

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Abstract

Objective In most developed countries, substantial disparities exist in access to mental health services for black and minority ethnic (BME) populations. We sought to determine perceived barriers to accessing mental health services among people from these backgrounds to inform the development of effective and culturally acceptable services to improve equity in healthcare.

Design and setting Qualitative study in Southeast England.

Participants 26 adults from BME backgrounds (13 men, 13 women; aged >18 years) were recruited to 2 focus groups. Participants were identified through the registers of the Black and Minority Ethnic Community Partnership centre and by visits to local community gatherings and were invited to take part by community development workers. Thematic analysis was conducted to identify key themes about perceived barriers to accessing mental health services.

Results Participants identified 2 broad themes that influenced access to mental health services. First, personal and environmental factors included inability to recognise and accept mental health problems, positive impact of social networks, reluctance to discuss psychological distress and seek help among men, cultural identity, negative perception of and social stigma against mental health and financial factors. Second, factors affecting the relationship between service user and healthcare provider included the impact of long waiting times for initial assessment, language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers, cultural naivety, insensitivity and discrimination towards the needs of BME service users and lack of awareness of different services among service users and providers.

Conclusions People from BME backgrounds require considerable mental health literacy and practical support to raise awareness of mental health conditions and combat stigma. There is a need for improving information about services and access pathways. Healthcare providers need relevant training and support in developing effective communication strategies to deliver individually tailored and culturally sensitive care. Improved engagement with people from BME backgrounds in the development and delivery of culturally appropriate mental health services could facilitate better understanding of mental health conditions and improve access.

Race, Culture & Mental Health

Black / Ethnic Minorities more often:

- Diagnosed as schizophrenic

- Compulsorily detained under M.H. Act

- Admitted as 'OffenderPatients'

- Held by police under S. 136 of M.H. Act

- Transferred to locked wards

- Not referred for 'talking therapies'

- Given high doses of medication

- Sent to psychiatrists by courts

<https://www.youtube.com/watch?v=hu0pgasAssg>

IDEALS OF MENTAL HEALTH

‘EASTERN’

HARMONY WITH OTHER PEOPLE
‘OTHER-ESTEEM’ VALUED

RELATIONSHIPS

BALANCE (‘ecological’)

KEEP OUTER WORLD CONSTANT
CONFORMITY WITH SOCIETY

FREEDOM OF INNER EXPERIENCE
VARIETY OF INNER EXPERIENCE

‘WESTERN’

INDIVIDUAL (SELF) SUFFICIENCY
‘SELF-ESTEEM’ VALUED

PERSONAL AUTONOMY

EFFICIENCY (‘machine-like’)

KEEP INNER WORLD CONSTANT
CONTROL ALTERED STATES OF CONSCIOUSNESS

FREEDOM OF EXPRESSION
VARIETY IN BEHAVIOUR

HISTORICAL CONTEXT OF PSYCHIATRY

Historical Events

1418	Portuguese voyage to West Africa
1492	Columbus reaches America Vasco da Gama lands in India Plunder of America Genocide of Americans
1577	African slaves landed in America Triangular trade: England sugar, cotton tobacco America slaves cloth, iron, rum, guns Africa
1764	British Occupy Bengal Plunder of India
1807	Abolition of Slave Trade
1839-42	Defeat of China in Opium Wars
1861	British occupy Lagos
1884	Berlin Conference: Scramble for Africa Plunder of Africa
1947	Liberation of India
1957	Liberation of Ghana
1963	Commonwealth Immigrants Act
1971	Immigration Act
1981	British Nationality Act

COLONIALISM SLAVERY

PSYCHIATRY

Growth of Psychiatry

1403	Bethlem Priory admits lunatics
1546	Bethlem Priory given to laity
1586	'Treatise on Melancholy' (Bright)
1621	'Anatomy of Melancholy' (Burton)
1632	Medical Governor of Bethlem
1713	Hospital for the Insane at Norwich
1734	'The English Malady' (Cheyne)
1744	Vagrancy Act
1774	Private Madhouses Act
1792	The Retreat for the Insane at York
1808	County Asylums Act
1841	Association of Medical Officers of Asylums
1858	'A Manual of Psychological Medicine'
1863	Broadmoor Hospital
1890	Lunacy Act
1930	Mental Treatment Act
1959	Mental Health Act
1963	British Journal of Psychiatry
1971	Royal College of Psychiatrists
1983	Mental Health Act

Racist Discourses in the 19th C

Do Black people have higher rates of 'insanity' (when compared to White people)?

1. (White) civilisation causes insanity

- So 'noble savage' is free of insanity

Supported by Tuke, 1858; Maudsley, 1867; Esquirol (Jarvis, 1852)

2. 'Savages' are mentally degenerate anyway (quoted by Aubrey Lewis, 1965)

3. Insanity levels (in US) among Blacks:

- Low when in slavery; High when set free (Anon, 1851)

Models of psychiatric pathology 19th C

‘Degeneration’ (Morel, 1852) ‘Born criminal’

(Lombroso, 1871) Dementia praecox

(schizophrenia)

(Kraepelin, 1896; Bleuler, 1911)

[‘Depression’ as melancholia goes back to Hippocrates]

Source: <http://www.sumanfernando.com>

Racist Theories in Psychiatry & Psychology

Idiots and 'imbeciles' suffer from 'racial throwback' (degeneration) to Ethiopian, Malay, American and Mongolian racial types (John Langdon Down, 1866)

Indians, Africans and North American Aborigines are 'adolescent races' equivalent to children of white races (Stanley Hall, 1904)

Javanese do not get depressed or suffer from guilt – 'psychically under-developed' (Kraepelin, 1921)

Psyche of (white) Americans liable to be pulled down by racial infection' of living too close to primitive black people (Jung, 1930)

Source: <http://www.sumanfernando.com>

Racist Discourse in Modern Times(Examples)

Africans did not get depressed because they lacked 'sense of responsibility' and their thinking resembled that of 'leucotomised Europeans' (Carothers, 1951)

Asians, Africans and African-Americans show less developed 'emotional differentiation' (Leff, 1973, 1977)

Racist IQ movement (Jensen, 1969) supported by Eysenck (1971,1973)
Repeated by Herrnstein & Murray (1994) and Rushton (1997)

Source: <http://www.sumanfernando.com>

Institutional Racism

‘The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people’.

The Stephen Lawrence Inquiry by Sir William Macpherson (Home Department, 1999: 28)

Source: <http://www.sumanfernando.com>

Institutional Discrimination

- Assimilation
- Under reaction or over Reaction
- Disempowering & stereotyping
- Service Led (rather than service user led) Approaches
- Poor access to services
- Erosion of rights

‘Count me in’ – Census 2013

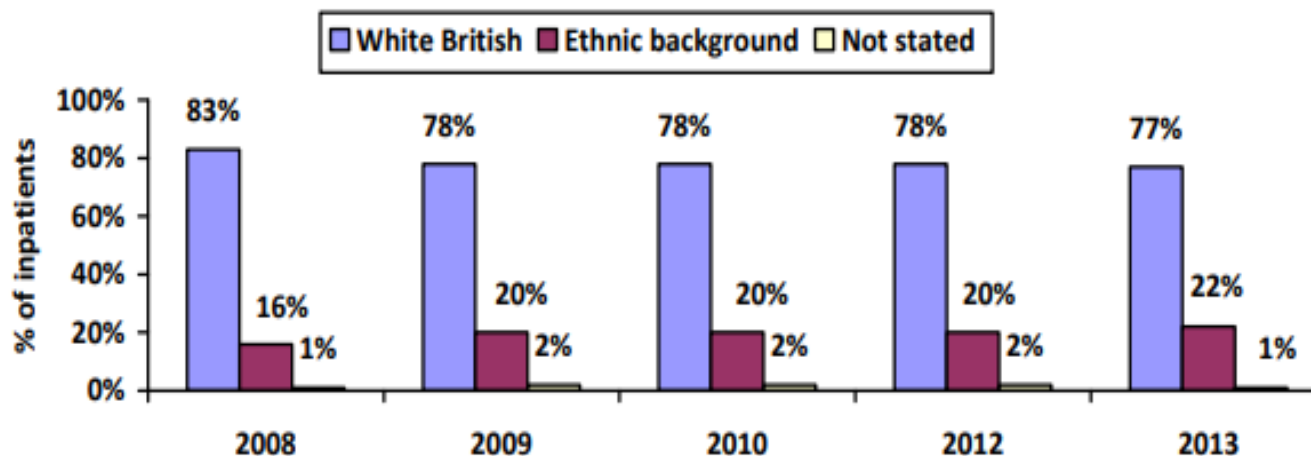
- Annual, 1 day count of inpatients, introduced March 2005 Joint initiative with the:
 - the Care Quality Commission (formerly Healthcare Commission)
 - the Mental Health Act Commission (MHAC)
 - the Care Services Improvement Partnership
 - National Institute for Mental Health in England (NIMHE).

The census aims to:-

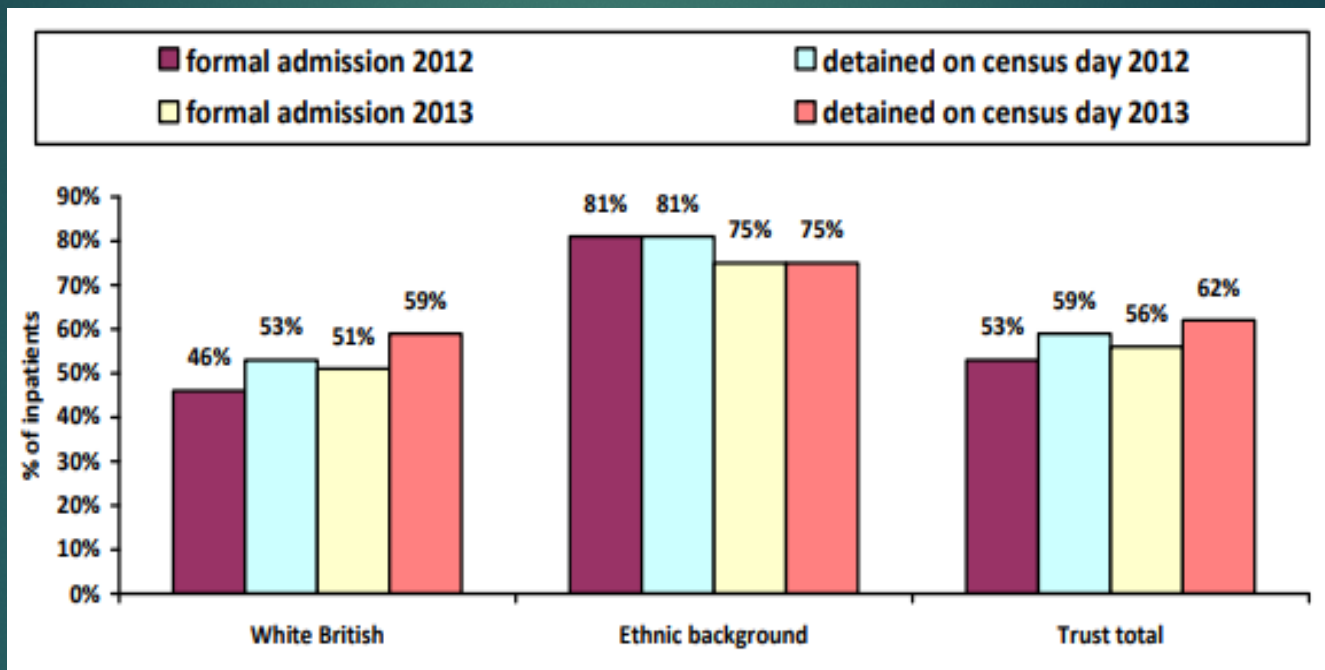
- 1. Obtain accurate mental health & learning difficulties inpatient figures in England and Wales.
- 2. Improve recording and monitoring of data on the ethnic group of patients.
- 3. Provide information to achieve the Government's five-year plan Delivering Race Equality in Mental Health Care (DRE) - aims improvement mental health services for black and minority ethnic communities.

‘Count me in’ – Census 2013

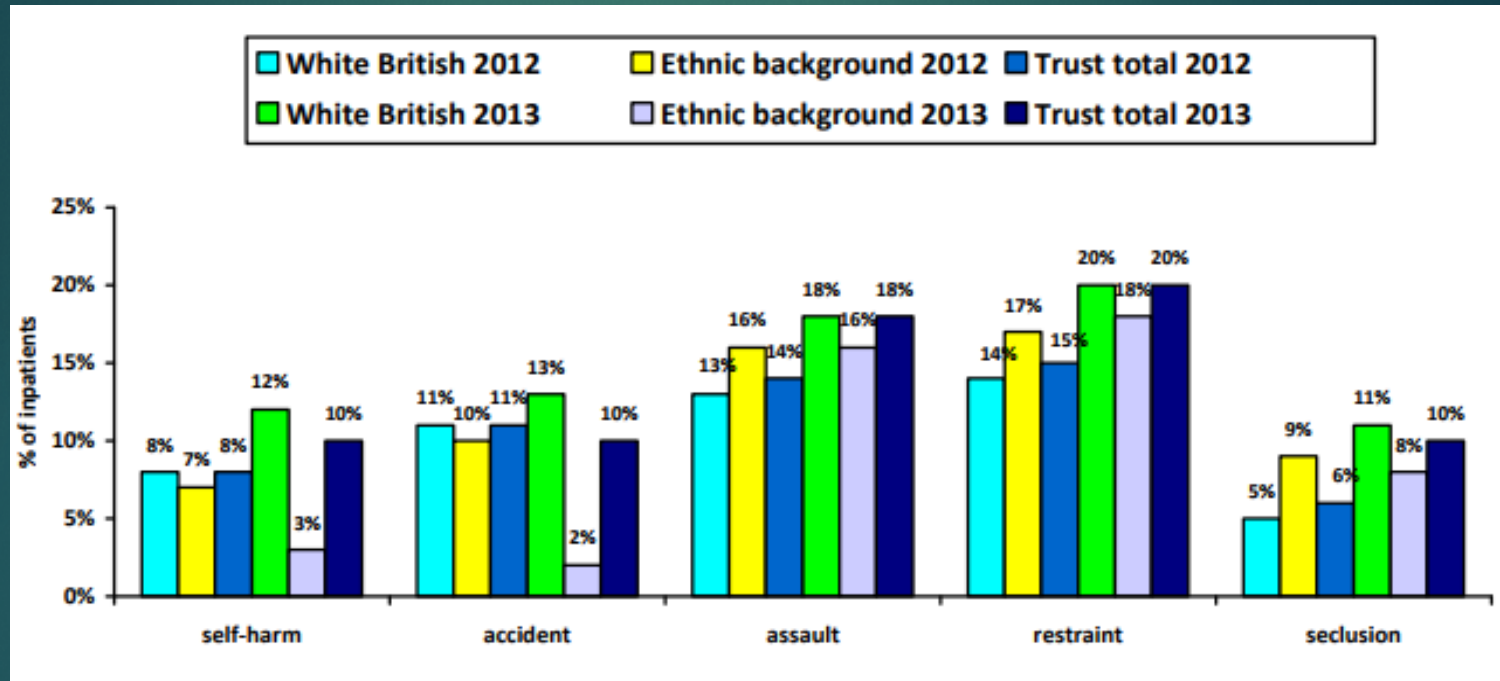
- In **2013** – 75 male inpatients, (26% of the total male patients) and 21 female inpatients (14% of the total female inpatients) were from an ethnic background (all none white British excluding ‘not stated/patient refused’).



‘Count me in’ – Census 2013



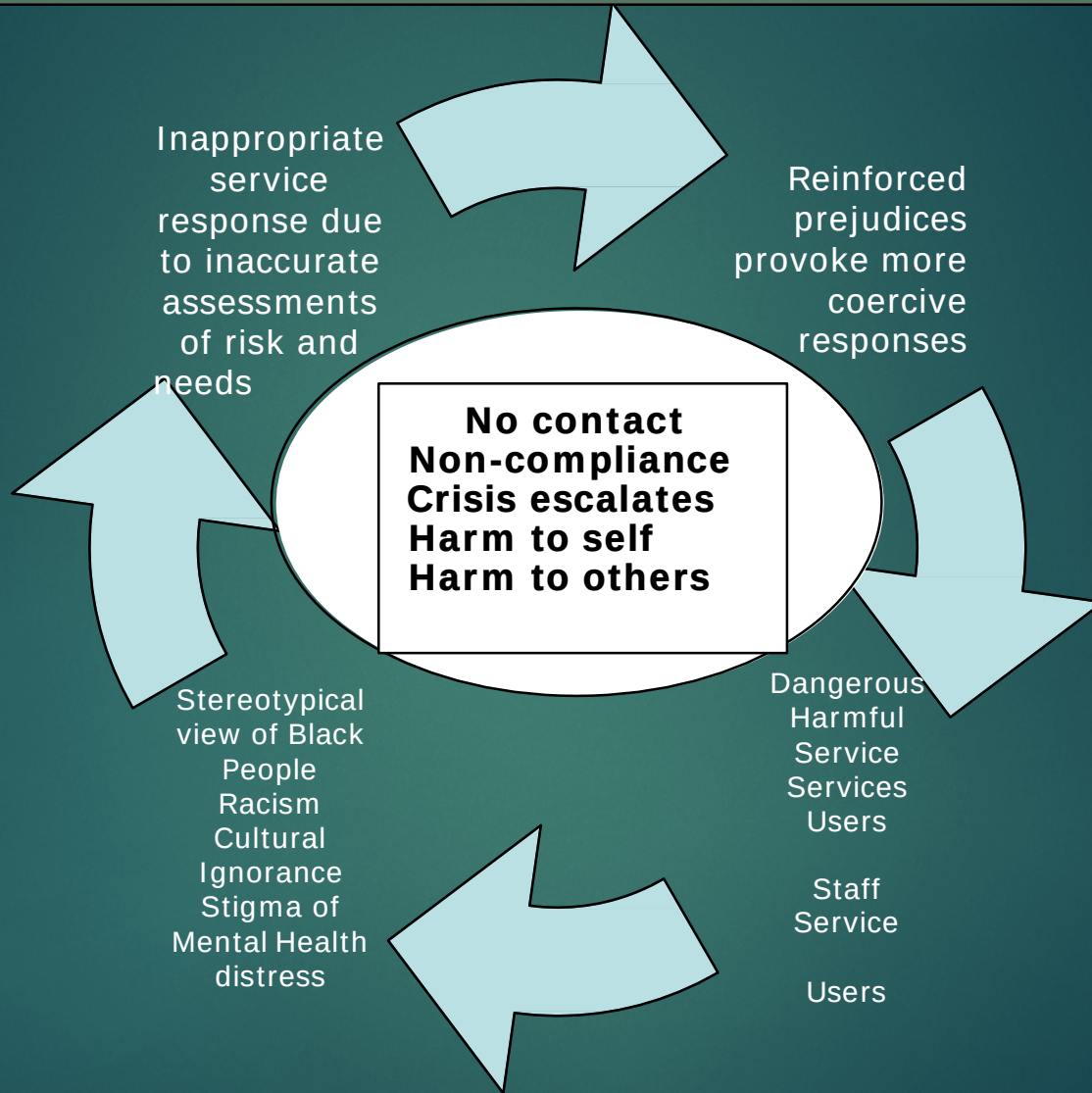
'Count me in' – Census 2013



‘Count me in’ – Census 2013

- In 2013 – 75 male inpatients, (26% of the total male patients) and 21 female inpatients (14% of the total female inpatients) were from an ethnic background (all none white British excluding ‘not stated/patient refused’).
- The percentage of patients detained has increased on census day from 59% in 2012 to 62% in 2013 - this increase may be attributed partially to some patients being admitted as informal patients but who were later detained.
- 427 (97%) of the total inpatients were recorded as having a mental health problem – 262 (97%) of total male and 157 (96%) of total female inpatients.
- 68/96 (71%) of the patients from an ethnic background were heterosexual, 1 person stated they were gay and 1 person stated they were bisexual and for 30 (31%) this was ‘not known’

A Perspective - Circles Of Fear



“There is a risk that, in places like X, people may never develop the awareness and skills to deal with Black people because there are so few of them”

Assumptions such as this may seem rather innocuous and commonplace but they can have very serious consequences. This quote was made by a consultant psychiatrist at the Norvic Clinic in Norfolk where David ‘Rocky’ Bennett, a young African Caribbean man, who died while being restrained. The psychiatrist had made the statement in response to questions from the Panel of Inquiry about ‘racial issues’ at the clinic (‘Independent Inquiry into the Death of David Bennett - December, 2003’).

Themes of equality:

Valuing Cultural Diversity

Preventative Approaches

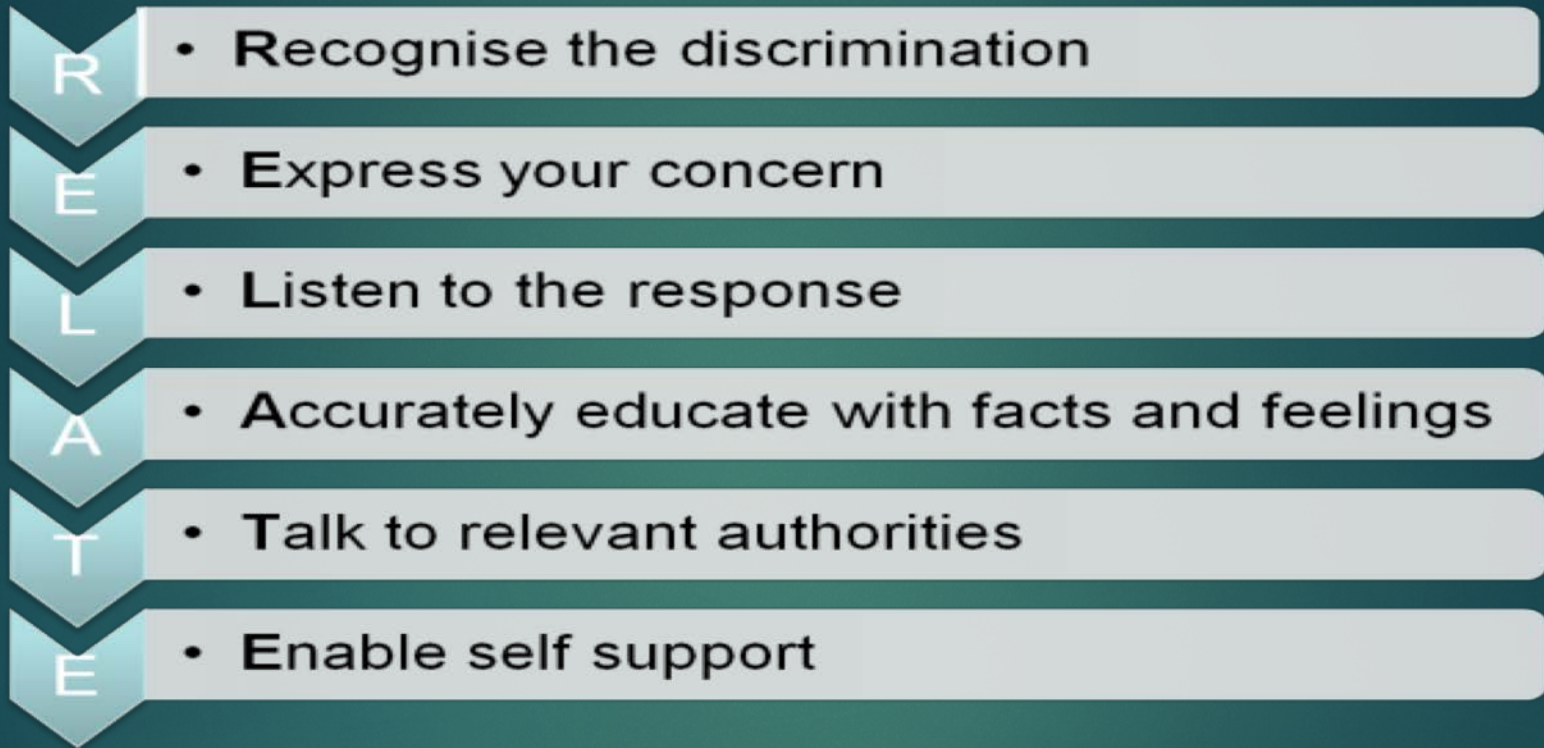
Autonomy & Advocacy Holistic
Approach Participation &
Information

Safeguarding Rights



The RELATE Model

(Hounsell, 2008)



Immigration

- Many tortured before arrival & many have gone through difficult & traumatic experiences in the course of getting here.
- Restrictive immigration rules mean immigrants have been refugees or asylum seekers.
- Refugees and asylum seekers feel intensely insecure in their political and social position within the UK.
- Facing all the problems that settled community BME people face but there are additional challenges for mental health services in providing for their needs.
- They face intense hostility & overt racism worse than black immigrants in the 1960s and 1970s.

Immigration

Service providers need to understand the help seeking practices of immigrants and refugees and through which a victim's trauma incubates or is internalized.

Practitioners and clinicians need to allow clients to teach them about what healing means in their culture or country of origin.

Establish professional relationship, high in trust with high personal outcomes.

Immigration

- Acknowledge language limitations on adequate self expressions of symptoms.
- Clinicians and practitioners need to consult with service providers who have expertise in serving African immigrant populations to upgrade their knowledge and skills.

British Asylum Laws

- Asylum Seekers are those people who are awaiting a decision.
- Refugees with Exceptional Leave to Remain (ELR) do not qualify as 'having a well-founded fear of persecution') but are recognised as being in great danger if they return home. Usually offered 'temporary protection' & the right to live here for up to 4 years.
- Refugees with Indefinite Leave to Remain (ILR) meet the UN terms, and have no time limit on their right to live in Britain. Majority of their rights are the same as a British passport-holder, and many settle here permanently.
- Refugees and those with ELR have the full entitlement to NHS treatment available to all legal residents in Britain, and do not have to pay fees. Asylum seekers whose cases have not yet been determined (including those with appeals pending) are also entitled. Those whose applications have failed where appeal processes have been exhausted and are entitled only to free emergency treatment.

Mental Health, Prejudice & Discrimination

“Stigma can therefore be seen as an overarching term that contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination)” (Thornicroft, Rose, Kassam, & Sartorius, 2007, p.1).

Discrimination: behavioural consequences of stigma which act to the disadvantage of people who are stigmatised (Sayce, 2000).

“The reactions of a host majority to act with prejudice in rejecting a minority group usually involve not just negative thoughts but also emotions such as anxiety, anger, resentment, hostility, distaste or disgust. In fact, prejudice may more strongly predict discrimination than do stereotypes” (Thornicroft, Rose, Kassam, & Sartorius, 2007, p. 2).