

A critical discussion and reflection on how cultural factors affect both definitions of mental health, diagnosis and treatment.

Global mental health

The movement for global mental health appears to be well-intentioned with advocates promoting equality and human rights for individuals in lower income countries to access mental health care and interventions (Patel et al., 2007). However, there are some within the movement who argue that this is intrinsically flawed due to the westernised medical model and approaches that are being implemented - effectively labelling and categorising emotions as a disease as opposed to finding methods to promote wellbeing (Cosgrove et al., 2020). I found this particularly interesting and key to rethinking how mental illness is viewed in a western society, largely the current system seems to tackle symptoms and Gardner & Kleinman (2019) argue that a fundamental new approach to thinking in psychiatry is required.

Taking this concept further, it could be argued that mental illness to some degree is a symptom, if the reason for distress or the underlying aetiology is heavily influenced by social constructs, economic, political, or environmental factors. This was something I really reflected on over this module and during research for the first assessment, it seemed to become evident that to effectively treat people who are suffering - then underpinning concepts of how mental illness is defined in society must be addressed on a larger scale. The practitioner needs to be aware of the personal circumstances in terms of culture, religion, spirituality, economic status, family and wider context in general - what views are considered 'normal' or 'abnormal' in order to avoid misdiagnosis (Gladding & Crockett, 2018). To some extent, one can understand how pharmaceutical approaches became so widely used in western society as a 'quick-fix' approach with time constraints for GP's being just one factor, however as Gardner & Kleinman (2018) argue, this approach is ultimately flawed. The prevalence rates for mental health would further emphasise the need for not only more culturally competent practitioners and effective training, but to promote alternatives to positive wellbeing such as community-based approaches, advocacy and self-empowerment in terms of one's own wellbeing and peer-support.

Reflecting on the scale of mental health diagnosis, depression is now considered one of the primary causes of disability worldwide (World Health Organisation, 2020) for which the response has been to increase psychological interventions, manuals and services. This 'scaling-up' of interventions from a westernised perspective as referred to by Cosgrove et al., (2020) may not be effective in addressing negative mental health issues, if conditions such as depression are only becoming more prevalent. It would seem to indicate that either the diagnostic criteria are flawed / overused or the underlying issues impacting people to cause such drastic prevalence rates, are not being addressed. WHO (2020) note that depression cases are more prevalent in women, therefore should seek to address why more women are prone to depression in terms of further research on potential biological factors be a

priority – or could the larger context provide further insight. It would be interesting to explore how many of the women diagnosed are from minority or poor socio-economic backgrounds.

Advocacy & Rights

The literature on social action therapy suggests that the wider issues that directly affect women, in terms of sexism, work inequality and the discrimination faced by those from ethnic minority backgrounds or lower socio-economic backgrounds, is either the root cause or major factor/s contributing to mental ill health (Holland, 2006).

Holland (2006) argues that the social and political factors are not being addressed (such as housing and employment) then direct consequences are that the individual continues to look inwards, manifesting in a cycle of self-blame, typically with the use of antidepressants which leads to the individual adopting a 'sick role'. Social action therapy, however, seeks to empower the individual to end the cycle of self-blame through advocacy and mutual support, it suggests that the most effective therapists are those who have training and crucially, personal experience and an understanding of the needs affecting working class population. Cosgrove et al., (2020) and Cheng et al., (2008) also refer to those with lived experience with mental health becoming more actively involved, looking at treatment or healing from a rights-based approach, promoting independence and to a degree, removing the patient role - I found the term 'affirming personhood' used particularly powerful.

Reflecting on my own understanding of mental health treatment in the UK, I find the alternative treatments which seek to empower individuals especially encouraging. As a practitioner, advocate, community member or service user - being provided with the tools to build on and maintain personal autonomy is crucial in eliciting hope, promoting confidence and a sense of self which I think is essential to positive wellbeing.

Eastern vs Western Concepts, Race, Religion and Spirituality

I found the historical and political context of how culture is shaped particularly interesting and vital to understand, especially in terms of how mental health perceptions, definitions and treatment models are influenced and subsequently implemented. Fernando (2014) references the historical and political context to give insight into how discriminatory views and lack of understanding of other cultures, reinforced racial stereotypes in mental health treatment and arguably still influence current medical models and perceptions. For example, the spiritual or tribal aspects of culture and healing were largely disregarded during colonisation, which is still reflected today in the lack of treatment models inclusivity of religion and spirituality (Pearce et al., 2014). The idea of understanding what is typically normal for someone in relation to their spirituality, religion, culture or indeed how they view the world, seems critical in terms of mental health and diagnosis, but appears to be commonly overlooked in western psychiatry (Gladding & Crockett, 2018). African tribes for instance have long used a

community and family-based approach towards those with mental illness, with better outcomes, less stigma and segregation (Fernando, 2010) the individual is treated as a whole person, encouraged to work on outdoor projects within the community – instilling a sense of self-worth, self-esteem and connectedness, whilst at the same time promoting understanding and acceptance within the community.

There is however increasing awareness of the importance and relevance of this aspect (from a holistic approach) when treating and understanding mental illness in some areas of western psychiatry, with groups such as the spirituality and psychiatry special interest group (Royal College of Psychiatrists, 2020) aiming to make developments specifically in this area. They are promoting research that evidences how spirituality and faith can be protective factors in terms of sustaining good mental health and wellbeing, emphasising how psychiatrists and patients (or individuals and therapists) can explore this aspect whilst building a trusting relationship.

It is highlighted that lack of training, understanding and time pressures can hinder the implementation of the spiritual aspect to care and support with mental health patients (Rogers et al., 2019) however, many of the key traits identified to become a spiritually or religious competent practitioner were interpersonal skills and attributes, such as empathy, a non-judgmental attitude, active listening, compassion, collaborative working and acceptance. The understanding of specific religious beliefs ideally this could be addressed in training, although the scale of this could prove time consuming and costly. However, by the practitioner utilizing and developing the core skills identified, whilst taking into consideration the person as a whole, including culture, religion or spirituality, this should in essence develop naturally if using a person-centred approach. The awareness of spirituality or religion being fundamental to a person as opposed to separate (Fernando, 2010) is something that I have certainly reflected on and resonated with.

The importance of how religion can affect mental health diagnosis, treatment and recovery was something I hadn't fully considered prior to this module, with the faith element largely unincorporated into treatment models (Pearce et al., 2014). However, the search for meaning and purpose is universally human, across religions and cross-culturally, with evidence demonstrating a correlation between religious or spiritual practices and higher levels of subjective wellbeing (Harrington, 2013). Displaying gratitude and practicing positive affirmations routinely have been shown to improve levels of wellbeing and happiness (Watkins et al., 2016) - in this context you could argue that prayer (being thankful, perceiving blessings) would elicit the same response. Therefore, reflecting on the literature, I would argue that incorporating meaning and value into treatments would prove effective, whether that's in a religious context, spiritual or secular and could be applied cross-culturally.

Looking further at historical movements and how colonialism shaped different cultures and political landscapes, it was interesting to note that the science and objectivity era in Europe during the 17th and

18th centuries was referred to as the 'Enlightenment era' (Fernando, 2014) whilst in Buddhist and Hindu religions this is referred to as achieving the highest form of spiritual state. Both definitions refer to mental liberation, awakened state and knowledge, but in a different context. This further emphasises how definitions and language can become 'lost in translation' or have different connotations in different cultures. This historical context of different cultures also explains how current treatment models in mental health in the UK are primarily devoid of faith and secular (Pearce et al., 2014) if the predominant thinking in the west centred on science and tangible results, which influenced the medical model in psychiatry.

Prior to this module my I had not fully understood the importance of structured religion in terms of it being a protective factor (Harrington, 2013), I can understand if it provides the person hope and meaning then it serves as a crucial and positive function in terms of maintaining good mental health. Looking to incorporate treatments, such as CBT with a faith or spiritual based element should be made more widely accessible, this modified approach focusses on community and looking outwards as opposed to the self and inward (Sabry & Vohra, 2013). If faith is important to the person then it appears to be an intrinsic element in terms of inner resources that they can tap into and take strength from, which seems highly important during times of crisis.

Community Approaches & Interventions

There does seem to be promise in the UK with more emphasis on practices such as mindfulness and yoga practices (NHS, 2018) for maintaining good mental health, which would previously be considered more alternative or complimentary therapies. This suggests that the UK are adopting knowledge and methods from other cultures, which is more inclusive of the eastern ideals and the mind-body connection (Fernando, 2010) and I particularly see hope in utilizing physical interventions for health and wellbeing, such as yoga, as it can be applied and understood cross culturally. The research on flow and goal-pursuit in positive psychology also confirms how mindfulness, which is essentially being present and living in the moment can be applied and understood cross-culturally (Harrington, 2013).

Community-based approaches to wellbeing, that are culturally inclusive appear to be promising, assuming they are accessible. Reflecting on my own strategies for wellbeing, I am fortunate that I can choose to attend a yoga or mindfulness class, in my own language (without having to wait for a referral) whilst also having the availability and capability to access online resources. Those seeking asylum, facing language barriers, homelessness or poverty largely due to socio-economic and environmental factors aren't in a position to do so. This is where I am particularly encouraged by free community initiatives that offer disadvantaged groups access to interventions in one place, whilst providing holistic support (Swansea Wellbeing Centre, n.d.).

Whilst there are schemes in place that offer support with housing and employment, the hope offered when the whole person is addressed, in terms of physical interventions and wellbeing, is extremely positive. Initiatives such as the Swansea Wellbeing Centre, offer free community yoga, relaxation and meditation classes as well as job search and projects such as the Bloom for refugee and asylum-seeking women and men's wellbeing support groups. The holistic and community approach is something that should be given further consideration in wider settings. As a practitioner or mental health advocate, being able to provide your skills and knowledge in a collaborative effort with those who are less able due to personal or environmental circumstances, is facilitating change not only on a personal level to that individual but also the wider community in terms of awareness and understanding.

Outlook

Initially it can appear overwhelming addressing the role of culture in terms of mental health diagnosis and treatment, however if focus shifts to more compassion-based therapies and creating more cultural competency through training and awareness, promoting individual rights and advocacy in mental health treatment - each area can impact the other resulting in better understanding and outcomes for individuals and communities.

Reflecting on my own perceptions of structured religion and mental health has been valuable, as I have always considered myself an inclusive person, being non-judgemental and accepting of others views and beliefs. However, being able to understand how religious views can potentially impact a person's recovery and effect their sense of self, is entirely different to simply accepting or acknowledging it. Drawing on personal experience, taking strength from it and becoming an advocate for others could effectively help to address the scale of social injustices and the impact on mental health for individuals and wider communities.

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