

Cultural Issues in Mental Health

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Chapter overview

This chapter covers the following topics:

- culture
- culture and health
- some specific health beliefs
- somatisation: symptom expression
- stigma
- acculturation
- migration and health
- culture and health care
- working with people from CALD backgrounds

Chapter learning objectives

After reading this chapter, you should be able to:

- describe the cultural issues that influence mental health and health care
- discuss different cultural beliefs related to mental health and health care
- explore the application of cultural safety to mental health nursing practice
- identify appropriate strategies for mental health nurses to work with clients from a cultural background other than their own.

Key terms

CALD (culturally and linguistically diverse) culturally and linguistically diverse refers to the characteristics of a society that make it multicultural i.e. the existence within the society of many different cultural beliefs.

Ethnic refers to a particular population, especially a language group.

Ethnocentrism refers to a belief in the inherent superiority of one's own group and culture accompanied by feelings of contempt for other groups and cultures.

Stigma refers to a mark of disgrace; stain, as on one's reputation or a sign of defect, degeneration, or disease.

Acculturation is the process of socialisation in which cultural elements and traits are adopted from the host culture.

Introduction

This chapter introduces you to the importance of culturally based health beliefs and practices to mental health and well-being and to health care delivered by mental health nurses. There is a need for mental health professionals to incorporate knowledge about these beliefs and to develop the skills to work with clients from cultures other than their own if they are to care for them effectively (Gorman et al., 2003).

Culture

Although most people would say that they know what *culture* is, most would have difficulty defining it, and few are aware of their own culture or the degree to which it affects their perception or expectations of other people. Culture is a major determinant of beliefs, morals and customs, and consequently behaviour. We live by thousands of rules, most of which we are not conscious of until we meet someone who breaks them, and then we commonly experience an emotional reaction that can range from discomfort to revulsion.

Tuck and Harris (1988) broadly define culture as ‘a major construct that describes the total body of beliefs, behaviours, sanctions, values and goals that marks the way of life of any people’. It is multidimensional, and includes the way we dress, our language, values, rituals or expectations for behaviour, the social control exerted through economics, politics and law, our artefacts, technology, what we eat and our food practices and, of course, health care.

Sadock and Sadock, taking a mental health focus, describe culture as:

a vast, complex concept that is used to encompass the behaviour patterns and lifestyle of the society ... Culture consists of shared symbols, artefacts, beliefs, values, and attitudes. It is manifested in rituals, customs, and laws and is perpetuated and reflected in shared sayings, legends, literature, art, diet, costume, religion, making preferences, child-rearing practices, entertainment, recreation, philosophical thought, and government. (Sadock & Sadock, 2007).

Whether the group is an **ethnic** group or group of people with a common set of beliefs, for example, those based on sexual preferences, age, or gender, the culture of the members of this group can be described as their *worldview*.

Much of culture is learned unconsciously through interaction with others in the cultural group, especially family, friends and school. Because cultural values are largely unconscious, expectations of other peoples’ behaviour are also. This means that our reaction to other people breaching those expectations tend to be emotional and judgmental. For example, in Anglo-Celtic cultures, failure to look someone in the eye when speaking can create suspicion that the person is dishonest. Conversely, in many other cultures direct eye contact is considered rude, disrespectful or even aggressive.

The unconscious nature of cultural values and beliefs tends to make us think that they are universal, so there is an expectation that all people, regardless of culture, will hold the same beliefs and values. This gives rise to **ethnocentrism**, where others’ behaviour is judged by the cultural rules of the observer. The tendency to believe that our own beliefs and values are universally right can lead us to judge other cultures as morally inferior to our own.

An important aspect of culture is that of the roles that individuals undertake in society, and how they—their rights and responsibilities—interact with each other. For example, in the Anglo-Celtic culture gender roles have traditionally relegated responsibility for providing food and disciplining the children to males, while caring for the children and looking after the house have been the responsibility of females. Today these roles have changed, with many couples sharing or reversing these roles, reflecting a broad change towards valuing equality; thus cultural values and beliefs are not static but change over time.

Symbolism is another aspect of culture that develops over time, and results in concepts becoming value laden, with the present members of the society not necessarily understanding their origins. An example of a powerful symbol in Anglo-Celtic cultures is that of Christmas. While Christmas originated in the Christian religion, most Anglo-Celtic Australians, regardless of their religious beliefs, consider it an important time, laden with non-religious positive values, and often associated with family rituals.

As a multicultural society, Australia has many different cultural groups of people. It would be a mistake to stereotype these groups, suggesting that all members of a group hold the identical values and beliefs to the same degree, or to imply that the groups are radically

different from each other. In reality, these cultural groups have more in common with each other than they have differences, and while members of a group have much in common, there are individual differences, and considerable variation can occur within groups.

Society needs its members to work together for the common good of all. In a multicultural society, that means that the different cultures need to meet and function together. For this meeting to be fruitful, the covert cultural values, beliefs, rules, behaviours and symbols that can create barriers to understanding and acceptance need to be addressed. There is no area of society where this is more important than in relation to health and health care.

Crosscultural research in the area of mental illness has concentrated on differential definitions, symptomatology and the treatment of a variety of illnesses.

Mental health services must be accessible and appropriate to all, and should address specific culture-related needs. Ideally, there would be adequate bilingual health professionals who are culturally sensitive and competent. But because it is impossible to match all clinicians ethnically with consumers, it is important for all mental health professionals to have a culturally appropriate approach to caring for **culturally and linguistically diverse (CALD)** people. Moreover, it is important that appropriately translated information packages are available to inform people from CALD backgrounds about availability of mental health services.

Stop and think!

- 1 What are the main reasons why you need to be culturally appropriate in your approach to caring for those from a CALD background?
- 2 How do your attitudes, beliefs and behaviours compare to the those described in the literature concerning CALD appropriate care practices?

Culture and health

As with all values and beliefs, those relating to health and health care are culturally derived and vary between cultures. Some examples of beliefs relevant to health include:

- the impact of external forces such as weather, spirits or supernatural forces, karma or luck
- the relative importance of the individual as opposed to community
- the role of emotions in illness, either causative or symptomatic
- the role of the family in care, ranging from virtually none to expecting that the family or the head of the family will make all decisions about care and treatment.

Different cultures define health differently. Anglo-Celtic culture classifies health and illness into quite specific categories, commonly based on physiological systems. There is a major division, for example, between mental health and physical health. This categorisation is alien to a number of cultures, which can, for example, view health as a very broad, holistic concept that not only does not distinguish between mental health and physical health, but also incorporates the idea of health and well-being of the entire community and of the land that community is attached to.

Some specific health beliefs

Beliefs about the causes of illness have an obvious relationship to beliefs about appropriate treatments. If you believe that an illness is caused by a cancerous growth, the removal of that growth can seem a logical treatment. If, however, you believe that the illness is caused by

inappropriate diet, then the logical treatment is to change the diet. The following are examples of a variety of beliefs about what illness or health may be attributed to:

- *yin and yang*: these permeate all of nature; yang representing the positive, male energy that produces light, warmth and fullness; and yin representing the female, negative energy, the force of darkness, coldness and emptiness
- *hot and cold*: foods are classified as ‘hot’, ‘cold’ or ‘neutral’, not in terms of temperature or spiciness but on other grounds: if a person complains of being ‘hot’, he or she does not necessarily have a fever but may have a symptom, such as constipation, dark urine or hoarseness, believed to be caused by an imbalance of heat in the body
- *good luck or leading a good life*, either in the past or the present
- illness caused by *evil spirits* or exposure to *polluting sources*, such as blood, sick people, and dead bodies; treatment is through purification rituals such as hot spring baths and herbal infusions
- *possession* by a demon, or the ‘evil eye’
- *air* (wind) or *water*: may be good or bad; a bad wind can act fast to induce high fever, convulsion and even sudden death; whereas bad water is believed to have a slower effect on health, causing chronic fever, anaemia or muscle wasting
- *ghost possession*
- *sorcery*.
Illness may be treated by:
- *tiger balm*, a mentholated ointment used for a variety of conditions, including colds, upset stomach, bruises and insect bites
- *tonics*, such as ginseng
- *coining*: creating small bruises on the body, commonly effected by rubbing the body with a coin or a spoon
- *a cloth wrapped around the abdomen* provides protection, especially for children, aged people and pregnant women
- *herbal medicine*
- *acupuncture*: the Chinese method of placing sharpened thin sticks into the skin at particular places on the skin
- *moxibustion*: the burning of small balls of moxa or dried mugwort on appropriate pressure points
- *ayurvedic medicine*: the ancient Indian medical system
- *cupping*: placing a hot cup on the body and letting it cool until the air contracts and draws the skin upward.

Ill-health is usually associated with suffering in some form. Suffering is also defined by culture, and how it is perceived, and the meaning attributed to it. The experience of suffering varies between cultural groups. Culture determines how a person should expect to tolerate suffering in a given situation, and how to behave. In some cultures, for example, labour pain is experienced as suffering, while in others it is more likely to be seen as normal. The degree to which pain should be expressed also varies considerably between cultures.

The response to pain by others is also culturally determined, so that judgments about and interpretations of people’s suffering by nurses are influenced by their cultural background. Anglo-Celtic cultures, for example, tend to endorse the attitude of ‘stiff upper lip’: denying the right of people to express suffering. Overt expression of pain may be labelled as ‘attention seeking’. This can lead to negative judgments about clients from other cultures, and even a resentment of the demands on the nurse’s time when asked to respond to complaints. This leads us into discussion about the impact of culture on the provision of health care.

Jack's story

Jack is a 30-year-old Aboriginal man who has been admitted with suspected schizophrenia. He suffers from hallucinations and delusions about dead people talking to him. English is not his first language, but he does speak broken English, and appears to understand everything that is said to him.

As he is unkempt and appears not to have had a shower for some time, the nurse attempts to encourage him to take a shower. He becomes aggressive towards her, and orders her to leave him alone. That night the nursing staff find him talking to someone, despite him being alone in his room.

When asked about it, he says he was visited by his dead uncle, who was advising him to leave the hospital. He tries to leave. Given his aggressive behaviour and his claims about his uncle, it is decided to keep him until an assessment can be undertaken. He becomes highly distressed and aggressive, demanding to be allowed to leave. Consequently he is placed in seclusion and sedated.

Eventually it is determined that he is not suffering a mental illness. His limited English and reluctance to discuss personal and cultural issues with members of staff (partly because of previous culturally unsafe experiences with health services) meant that they were not made aware of the real reason for his behaviour.

First, already feeling unsafe, he was appalled that a female would attempt to make him take a shower, and naturally he responded aggressively.

Second, his seeing and speaking to a dead relative was culturally normal. His uncle had recently died, and, as a significant person in his life, taking on a guidance role with his nephew, it was not unusual for him to appear to give advice.

- *Cultural safety* requires that the client feels that his or her culture is respected, and that the person is not judged by the values of another culture. What steps could have been taken to ensure that this man's cultural values were taken into consideration?

Somatisation: symptom expression

Many people migrate to Australia under traumatic circumstances. Therefore it would be reasonable to assume that mental health service utilisation would be high. However, this is not the case. Many researchers have found that service access by CALD groups is significantly low (Klimidis et al., 2000). One needs to examine the belief systems of a cultural group to glean an understanding of the reasons for this lack of utilisation of services. It has been noted that some adults do not willingly self-disclose mental illness symptoms, and view mental illness as stigmatising, both for themselves and for their family. People may be feeling wretched within but be outwardly smiling. Some researchers support the custom of somatisation as a means of expressing psychological difficulties. This however, is also seen in Western cultures. We could assume, therefore, that CALD clients might not meet criteria for some mental illnesses because of a failure to report some of the psychological symptoms (Kiriopoulos, et al., 2005).

Somatisation refers to the expression of physical symptoms that are not explained by observable organic pathology, and may be a result of hypochondriasis or as somatic manifestations of anxiety and other disorders. Early researchers deduced that somatisation is more likely to be observed in non-Western societies than in Western societies, but non-Western writers have suggested that much of the research into physical complaints exhibited by non-Western people have been conducted using a Western framework, and as such lose validity because cultural conditions have been ignored. Moreover, cultural stereotypes have contributed to the assumption that the non-expression of emotions is an expected feature for certain cultural groups (for example, Asians). Perhaps the presentation of physical symptoms satisfies the twofold objective of gaining entry into the service system and to maintain social acceptance and support among communities where mental illness is strongly stigmatized.

Somatisation has been described as a universal phenomenon. In Britain, more than 50 per cent of people with a mental illness had solicited help for physical problems, and in the

United States, up to 70 per cent of those with diagnosable mental illnesses present with somatic symptoms. The World Health Organization (WHO) multinational study of mental disorders in primary health found high correlations between observable psychological problems and somatisation (Uston & Sartorius, 1995).

Although it has been traditionally believed that somatisation occurs predominantly in non-Western countries, the reasons offered to explain these beliefs have varied. Some claim that people from low socioeconomic status (SES) and who are illiterate are considered to have inadequate language skills to communicate their emotions verbally, and therefore express their psychological distress through physical symptoms. In a few cultures there is no language equivalent for certain psychological problems, and overt expression of feelings is seen as a sign of weakness and is socially undesirable. The harmful social consequences of mental illness and the associated stigma may prevent the reporting of psychological distress in these cultures.

The International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual (DSM) include somatisation under the axiom of *somatoform disorders*, whereby people have constant physical complaints despite reassurances that there is no organic pathology to explain them. These ongoing symptoms result in impaired social and familial functioning.

Stop and think!

- 1 What are some of the reasons why cultural groups do not access mental health services?
- 2 How would you integrate cultural behaviours and practices into your nursing assessment of your client?
- 3 Describe how symptom expression differs between cultural groups.

Stigma

The word **stigma** has its origins in Greece. It means, ‘to mark the body with a burn or cut to signify that the person is shameful’. With time, its meaning has evolved to refer to a mark of disgrace. It is more than just a negative connotation. It invokes rejection, stereotyping and discrimination (Ng, 1997). At the moment, most forms of discrimination have slowly weakened, although there remains room for improvement in some areas. It is now socially and legally intolerable to discriminate against or ridicule someone (that is, *stigmatise* them) on the basis of their ethnicity, religion, sexuality or disability.

Mental illness still creates confusion, prejudice and fear. Some people with mental illness state that the stigma can be worse than the illness itself. People may be less prepared to offer support and empathy to someone with a mental illness than a person with a physical one. Some people with a mental illness have found that others become awkward or suspicious around them, and that they lose connections with family and friends. If it is known that people who have had a mental illness sometimes find it more difficult to find employment or gain a promotion, even if they are well at the time (Crisp et al., 2000). The stigma surrounding mental illness are not confined to Western cultures.

A large Australian study exploring stigmatising attitudes towards mental illness by people from CALD communities was conducted by Rooney and colleagues (1998). Data were collected through focus groups, indepth interviews with people with mental illness and their family and carers and interviews with mental health workers. They found that in all groups there were very negative attitudes and behaviours toward the mentally ill and their families. Most communities had limited knowledge of mental illness. The knowledge that did exist was based on myths and inaccuracies about the cause and treatment of mental illness. Contributing factors, such as the migration experience, cultural alienation, language barriers

and loss of status were offered to explain why some people experienced mental illness. Negative attitudes were associated with somatisation and religious and spiritual beliefs.

However, the post-migration experience has positively influenced their attitudes, so that the mentally ill have become more visible, positive treatment outcomes are being observed and greater tolerance and understanding in Australia have developed toward the mentally ill. Mental illness is still viewed as a family responsibility, and generally hidden from the community.

Help-seeking is lessened because people will not acknowledge that mental illness exists, they fear stigma and they fear being 'locked up' for life. Men are more likely to indulge in alcohol to cope with their problems, because help-seeking is seen as a threat to their masculinity. Women avoid help because of social isolation, the dual burden of work and family responsibilities and the consequences of varying forms of abuse they have endured throughout their lives (Rooney et al., 1998).

Stop and think!

Mental illness still creates confusion, prejudice and fear within the general community.

- 1 What do you believe are some of the reasons for community confusion, prejudice and fear of those who experience mental illness?
- 2 How can you, in your capacity as a nurse, work towards minimising the negative impact of confusion, prejudice and fear related to mental illness?

Acculturation

Acculturation is the process whereby migrants acquire the values and behavioural norms of the host country. Simple acculturation occurs when new residents become more like host residents over time (Ryder et al., 2000).

In the *damaging culture model* (Buriel et al., 1982), there are major differences between pre-migration cultural values and attitudes and host country values and attitudes. Pressures to assimilate cause distress among the newer migrants who are less acculturated. Buriel and colleagues (1982) further state that the complete giving up of one's traditional culture may have deleterious consequences. They consider that using aspects of both cultures permits the individual to function in both cultures, and is protective against psychological distress. Nevertheless, higher levels of acculturation may cause psychological distress because of relinquishing traditional ways or by adopting host country ways. The partially acculturated individual is marginalised from both cultural groups, and is pressed to fully assimilate while at the same time experiences barriers to that assimilation.

The acculturation literature is mixed. Not only does it lack clear evidence for any of the theoretical perspectives, but the evidence that exists is contradictory. Almost equal numbers of studies support either a positive or negative relationship between acculturation and mental health. Acculturation is different with different populations, and varies with the instrument used to measure it.

Measuring acculturation is achieved conceptually, using scales that address the adoption of dominant culture values as well as those that measure linguistic fluency as a means of accessing the dominant society. There is a strong relationship between mental health service use and level of acculturation, whereby those being more acculturated have greater service use. Neff and Hoppe (1993) conducted a community survey to measure acculturation and other demographic factors in depression. Socioeconomic status (SES) is an important issue that needs to be addressed when discussing relationships between ethnicity and psychological distress. Further, the influence of SES is related to whether the population is more urban or more rural in nature. In their study, Neff and Hoppe (1993) found that

younger, more highly educated migrants were more acculturated, and became similar to natives. Married women also scored higher levels of acculturation. However, they found little evidence of acculturation being inherently stressful. Many acculturation effects could also be explained by socio-demographic factors. A few studies examining acculturation and depression among Latino populations have shown that higher levels of acculturation are associated with higher levels of depression (Davilla et al., 2009).

Jay's story

Jay is a 50-year-old Malaysian man who has been working in Australia managing his own small business. He speaks some English, but his wife speaks very little.

He is admitted suffering from depression, and tends to sit in his room and avoid interacting with anyone except his wife when she visits.

He refuses to eat the food provided to him, and staff are not sure if this is because of a lack of energy and appetite or if he is trying to starve himself.

Attempts to encourage him to eat result in aggressive verbal responses, and when a nurse tried to spoonfeed him he knocked the food from her hand.

Staff have become increasingly frustrated by his behaviour, and it is decided to commence tube feeding, when one of the staff discovers his wife smuggling in food to him.

Initially staff are quite angry at what they perceive as an attempt to feign starvation. It is decided to call in an interpreter to discuss this with him and his wife. Only then is it discovered that they are Muslims, and he has been refusing to eat any food not prepared by his wife as he is concerned that it is not *halal* (prepared according to Muslim Law).

If staff were practising cultural safety, this should not have happened.

- What culturally safe practices could have avoided this situation?

Migration and health

Being a member of a minority culture

Although immigration requirements ensure that migrants have a high standard of health, many minority groups, including ethnic minorities, are commonly disadvantaged in society.

Cultural and linguistic barriers to utilising a health care system that they are unfamiliar with can have an accumulative effect on top of a reduction in socioeconomic status and in support systems such as family, friends and carers. Compounding the above, many migrants experience culture shock, discrimination and racism, all of which can result in a mistrust of the health care system and make them reluctant to participate in health care.

Torture and trauma survivors

Numerous people migrate following traumatic events in their home country, and many are refugees who have experienced torture. There is a relationship between torture and psychiatric symptoms, especially in ex-political prisoners. Ex-political detainees experience more trauma events than comparison groups, and they demonstrate higher rates of post-traumatic stress disease (PTSD) and depression (Fazel et al., 2005). There is a positive correlation between cumulative torture experiences and psychiatric symptoms. These findings suggest that torture is a causal factor in the development of PTSD and major depression.

Others have reported levels of psychological distress in pre-migratory refugee populations, and have found higher levels of depression than in non-migratory samples. These results are probably a result of pre-migratory trauma, but could also be attributed to other situational factors or selection biases. Some reports have indicated that refugee camp experiences may be instrumental in contributing to psychological distress among refugees (Fazel et al., 2005). Nevertheless, McKelvey and Webb (1997) investigated camp conditions

and social support in a sample of 101 refugees, and concluded that levels of psychological distress were not related to camp conditions or social support within the camp.

Pernice and colleagues (2009) state that post-migration factors are more likely to be related to depression and anxiety than demographic characteristics. Such factors include host country discrimination, isolation and loneliness, unemployment and the detachment of ethnic enclaves affected by anxiety and depression. Immigrants who had arrived within six months expressed symptoms either of anxiety, depression or both. Those who had been residing in the host country for longer than six years appeared to experience lower levels of depression, suggesting that mental health may improve over time. Religion and gender mitigate the effects to some extent. For example, Buddhists are less like to express depression or anxiety than other religious groups among migrants, and males are also less likely to experience anxiety than females.

Much of the research regarding ethnicity and mental illness has been descriptive. Moreover, this research has depended on treatment rates and case identification to estimate rates of illness. They do not address the untreated population, and are therefore limited for identifying causality. They often express different pathways to treatment rather than illness per se, and the attitudes expressed are embedded in Western psychiatry, so fail to explain any potential cultural differences in either expression or experience of illness.

Stop and think!

- 1 What factors do you think would lead to migrant mistrust of the health care system?
- 2 How would you enhance access and utilisation of health care services for migrant groups?
- 3 What further research is required to explain the potential cultural differences in relation to expression of, and experience of mental illness?

Culture and health care

Australia's health care system is based on Anglo-Celtic cultural beliefs about health, health-related behaviours and health care. When clients from non Anglo-Celtic cultures need to access health care services, the differences between their cultural beliefs and values and those of the health care service provider can create barriers to them receiving appropriate care (Gorman et al., 2006).

Health care in Australia is based on scientific knowledge. Treatment regimes are formulated on the basis of what is believed to be scientifically proven data about cause and effect. Belief in the scientific method is very strong, and this increases the ethnocentric tendency to believe that the care is unquestionably correct. Even if this belief is correct, the success of treatment is highly dependent on the patient believing in it and in the health professional. Without this belief in the treatment, it less likely to be effective and some patients are less likely to participate in it.

Australian government policies emphasise equity for all cultural groups, but to meet this requirement for equity, staff need to be able to understand their clients' needs and their cultural perspective of those needs. If this is not the case, patients can be seriously disadvantaged in terms of the care they receive. One fundamental requirement for meeting a client's needs is effective communication between the client and the health care professional. Cultural differences can impede communication, and this can be exacerbated further if the client comes from a non-English-speaking background.

Lack of information about treatment has been identified as being a major disadvantage of non-Anglo-Celtic mental health patients in Australia (Comino et al., 2001).

A failure in communication can result in:

- the client's lack of knowledge of the purpose or side effects of drugs

- admission without knowledge of the treatment to be given
- treatment without consent
- misidentification of patients
- inappropriate discharge
- culturally inappropriate treatment; for example, the administration of a blood transfusion to a patient whose religious beliefs forbid it, or the administration of oral medications that contain alcohol to a patient whose culture forbids the intake of alcohol.

Utilisation of services

Collecting information about patterns of service use by migrants is achieved using a variety of criteria. Unfortunately these criteria are not uniform, which means that comparisons cannot be made. Other limitations in the research surrounding service utilisation have made interpretation of the results difficult. Limitations relate to the information gathered on treated populations only; the unreliability of cross-cultural diagnosis; incomplete records; cultural reliability and validity of standardised instruments; problems with self-reports; and the costs associated with large sample sizes. What we do know is that CALD groups generally underutilise mental health services.

An important report was published in 1997 by McDonald and Steel, providing an overview of the epidemiological profile of the mental health of immigrants in New South Wales. This report delves into some of the key issues related to the mental health of migrants. Overall, McDonald and Steel (1997) found that people of CALD backgrounds have markedly lower hospitalisation rates than people of the broader community, and that these rates are consistent over a six-year period; though rates for groups from Northern Europe are up to 140 per cent higher.

It could be assumed that there might be a commensurate increase in the access to community services to even out the low hospitalisation rates, but here also the rates are significantly lower for CALD groups. Yet the prevalence of mental health problems does not appear to be lower. Phan (2000) notes that Vietnamese people do not readily utilise mental health services of any type.

CALD people tend to have longer average lengths of stay in the public system, especially for depression and schizophrenia and their related disorders. Furthermore, they are inclined to stay until they are considered well enough for discharge by clinicians, and have lower 28-day readmission rates. There are no significant differences in the numbers of occasions of service for community service provision.

Although overall hospitalisation rates are lower than average, the proportion of those hospitalised involuntarily is up to three times higher, which suggests that people from CALD backgrounds do not voluntarily seek admission. Moreover, they are more likely to be placed on a community treatment order. They are overrepresented in the forensic population (McDonald & Steel, 1997).

Offering similar epidemiological data, British researchers found that there is a higher proportion of black patients; they are admitted involuntarily; are located in secure wards; are more likely to have a diagnosis of schizophrenia; and not be registered with a general practitioner. Approximately 33 per cent of people with mental health problems do not consult a GP, and 50 per cent go undiagnosed because of a failure by the doctor to recognise symptoms (Commander et al., 1997a, b).

Maria's story

Maria, a 40-year-old South American woman, is admitted unconscious to an emergency department as a result of a car accident. She has a fractured skull caused by the accident. She regains consciousness shortly after admission, and becomes increasingly agitated. The treating team decides to give her some sedation to calm her down. When the nurse approaches her with the medication she starts screaming and jumps out of the bed, knocking down the nurse and a doctor in the process.

When staff approach her she becomes even more hysterical and attacks them, scratching their faces and attempting to gouge their eyes. She is restrained, and a psychiatric evaluation is carried out.

After some time it is discovered that she is a refugee who suffered torture and abuse, which were carried out with the aid of health care staff. As a consequence she was suffering from post-traumatic stress disorder triggered by finding herself in the hospital environment, which she associates with the previous traumatic experiences.

It is not uncommon for refugees to have had horrific experiences, often inflicted by government officials. In countries where torture is considered a legitimate means of interrogating prisoners, medical and nursing staff can be involved to ensure that the prisoner survives the experience. In this particular scenario, it would have been very difficult for staff to have anticipated the possible reaction, but in situations involving refugees, the likelihood of highly traumatic life experiences should be anticipated.

- 1 What sorts of things should you consider when working with clients who may be refugees?
- 2 What sorts of strategies could you implement when working with refugee clients to minimise the risks?

Working with people from CALD backgrounds

When clinicians show respect for cultural differences and attempt to demonstrate cultural understanding as well as use appropriate cultural resources, the therapeutic alliance is enhanced (DeRosa & Kochurka, 2006).

An important point of clarification needs to be made. There is a great difference between cultural competence and cultural sensitivity. Although many clinicians are sensitive to the cultural issues and needs involved with mentally ill clients, they may not be competent to deliver culturally compatible care. Many clinicians evolve their own unique ways of incorporating cultural sensitivity into their practice. However, few have had formal cultural studies, and most learn about cultural differences through interactions with people from other cultures. Whether the care they provide to clients is actually culturally competent or not is cause for question.

Ethnic similarity

Being able to enter into the world of the client from a common framework enables the clinician to make sense of the client's distress and work towards a mutual understanding of the psychological problems (Gorman et al., 2003). Others have explored the importance of clinicians and clients experiencing similar languages, thought processes and beliefs about the nature of the world and the causation of mental illness, and conclude that sharing a worldview is inherently therapeutic. Many other writers have explicated the benefit of a shared worldview when assisting with the acceptance of diagnosis, treatment and expectation for change (include examples of studies). The empathic resonance and degree of consensual understanding predicts the therapeutic outcome. Importantly, within the literature regarding a shared worldview, the issues of clinician credibility arise. Clinicians are seen as more credible when the client has considerable similarity to the clinician, leading to greater satisfaction levels for both client and clinician, higher levels of self-disclosure and reduced likelihood of discontinuance with treatment. Unfortunately, ethnic matching in Australian mental health services is poor, despite a large number of bilingual clinicians working in the area (Minas et al., 1994). Some clients are culturally matched with their clinician. Some

clinicians are also from CALD groups, and have clients from other CALD groups. The nature of these dyads increases the complexity of the relationship.

When clinicians engage in culturally responsive interactions, such as showing interest and appreciation and demonstrating knowledge of culture and ethnicity, as well as contextualising the client's problems, they are seen as highly credible (Griffiths, 2006). Earlier, Fischer and colleagues (1998) referred to a *common factors framework* to assist culturally dissimilar clinicians attain credibility. These common factors are the therapeutic alliance, shared worldviews and acknowledgment of client expectations and mutual decision-making about rituals or interventions. When the culturally dissimilar clinician endeavours to work within the framework, cultural awareness is promoted.

Implications for clinicians

First, clinicians should use an approach to assessment and interactions which acknowledges the divergent attitudes, values and behaviours embedded in specific cultures. This serves as a basis for assigning meaning to concepts either across or within cultures. Through the understanding of such meanings, specific information relevant to the individual and diagnosis will be encouraged.

Second, standardised instruments should be applied in culturally sensitive ways. The results of psychological tests should be interpreted with regard to cultural data. Translated versions should be used whenever possible, provided the translation has been carried out accurately and expertly, and that validity and reliability data exist for comparison. Consulting with cultural experts will assist this process.

Third, non-standard methods offer alternatives to fixed-format assessment procedures that have been normed on dominant culture groups (Ridley et al., 1998). Non-standard methods include post-assessment narratives that allow clinicians to gain insights into how culture influences client responses and disclosures during the formal interview and potentially modify diagnosis on this basis. Constructivist strategies are also helpful in understanding how clients construct and disclose reality, and may be used with verbal or written narratives, groups and journaling. Other non-standard methods include ethnographies (Ware et al., 1999), case studies, picture-story techniques and narrative accounts (Ridley et al., 1998).

Fourth, culture-specific instruments that have been tested for a given population are more accurate in reflecting cultural experiences, values, and personality traits than Western conventional instruments. Clinicians need to be thoroughly trained in the use of these instruments or, alternatively, refer to a professional who is.

Fifth, the DSM-IV-TR (American Psychiatric Association, 2000) allows for the clinician to identify culture-specific disorders and other manifestations such as acculturation difficulties in relation to minorities. However, the manual does not provide adequate practical guidelines for implementing cross-cultural assessment and appraisal, and therefore remains biased. Hence, it should be used cross-culturally with care. It is important that diagnostic taxonomies include guidelines for the accurate and comprehensive assessment of people from non-dominant cultures.

Sixth, a client's worldview is the sum total of his or her values, beliefs and perspectives about human nature, social relationships, nature, time and activity. It is influenced by the client's socio-political history and cultural and gender identity. By understanding the client's worldview, clinicians are provided with a 'phenomenological, experiential context for the assumptions held by the client' (Lonner & Ibrahim, 1996, p. 296). Clinicians need to explore the client's frame of reference with a view to facilitating therapeutic engagement.

Seventh, cultural belief systems about mental health and illness will influence the client's response to the psychiatric interview and expectations for treatment. Therefore,

Careful explanation of the purpose of the procedure is crucial to avoid misunderstanding and potentiate accurate diagnosis. Thorough explanations and assurances of confidentiality also increase the likelihood of engagement. Modifying and using diverse treatment modalities that are compatible with the client's expectations will ensure greater follow-up and compliance. Moreover, it will encourage disclosure from the client about troubling issues related to treatment; for example, disclosing medication side effects leading to adjustment of dose or replacing it with another medication rather than simply deciding not to continue to take the medication.

Eighth, establishing credibility with the client can be achieved in a number of ways (Hwa-Froelich & Vigil, 2004). They include the display of professional qualifications, taking time to listen to clients' stories from their perspective, giving understanding, advice and treatment and respecting difference. Provided that the client doesn't perceive a power imbalance and reject the relationship because of professional displays, the other interpersonal skills will assist with establishing credibility (Griffiths, 2006). Clinicians should learn to enhance their credibility with a variety of different cultural groups rather than attempt to learn the specific healing remedies and techniques of individual cultures. Therefore broad principle-based interactive skills are more important than amassing discrete knowledge about individual cultures.

Ninth, clinicians need to expand the boundaries of their professional interactions. Clinicians demonstrate commitment and interest in the individual when they conduct their work in the environment of the client. It provides a common ground to establish a shared worldview, and advances the prospect that clinicians can assist them (Gorman et al., 2003).

Obtaining cultural knowledge is a continuous process. Clinicians need to consult with and be supervised by knowledgeable colleagues to ensure that cultural knowledge is applied in a competent way and that clients are seen as individuals first and members of a specific cultural group second.

Meng's story

Meng, a 65-year-old Chinese woman, is readmitted to hospital in a psychotic state. She has been admitted periodically over many years, her stay followed by treatment in the community, but has a history of noncompliance with her antipsychotic medication, resulting in her readmission. Her English is poor, and she relies on her son to communicate for her. Meng responds to medication and her psychotic symptoms subside.

- 1 Given that Meng comes from a Chinese culture, what might be some of the reasons for her noncompliance?
- 2 What strategies could you implement to try to bridge the gap between her worldview and that of the treating team?
- 3 What information would you want to acquire to enable you to provide culturally appropriate care?
- 4 What strategies would you implement to ensure appropriate communication with Meng?

Stop and think!

If values, beliefs and behaviours differ between cultures, it stands to reason that to understand and deal with these differences you need to be aware of your own values, beliefs and behaviours. Take the time to consider the rules that you live by; these will give you an insight into your values and beliefs and help you to become conscious of them. That way it becomes easier to see them as cultural rather than universal, and therefore to be less judgmental.

Summary

Our beliefs, morals, customs and the rules we live by, and consequently our behaviour, are largely determined by our culture. As these are mostly unconscious, we have a tendency to think of them as universal, and therefore to expect others to fit our expectations. This leads to ethnocentricity and the risk of judging others by our rules. When working with people from cultures other than our own, we need to be aware of our rules and expectations and the fact that these are not universal but cultural, to enable us to undertake culturally safe practice.

Most people who are not from the dominant mainstream culture are migrants, and some of them are refugees. Migration and refugee experiences can have significant implications for mental health, which can be complicated by culturally unsafe practices on the part of health professionals.

We as mental health professionals have an obligation to ensure that our clients are not disadvantaged by our practices.

Discussion questions

- 1 As a mental health nurse, what have you learned about working with people from cultures other than your own?
- 2 What are your values and beliefs about health?
- 3 How would you feel if you were working with a client who went against them?
- 4 Given the need to be culturally safe, what would you do when you found yourself in a conflict about health values?
- 5 Having read this chapter, what would you now do differently when working with clients from a culture other than your own?

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