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## Chapter 12

### **Race and Cultural Diversity: The Training of Psychologists and Psychiatrists**

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#### **Introduction**

How issues of cultural diversity are dealt with or not, in training psychiatrists and psychologists and mental health professionals is an important issue. This is noted in policy documents produced by the Royal College of Psychiatrists (2013) and the British Psychological Society (2013). It will determine to some degree if the psychiatric or psychological services these professionals offer when qualified, are appropriate and accessible to all (James & Prilleltensky, 2002; Marsella, 2011; Newland & Patel, 2014). Making mental health professionals aware of the importance of these issues during training and of the possible limitations of western psychological theories sometimes generalised unthinkingly to other contexts, can only widen the applicability and relevance of psychological and psychiatric knowledge to the benefit of service users nationally and internationally (Fernando, 2010; Bhugra & Gupta, 2011; Lane & Tribe, 2010). Although many mental health professionals may state a desire to encourage criticality and to consider the limits of knowledge, this is not always easy in the face of long-established traditions, organising principles and models of working, let alone

established or vested interests and power structures (Howitt & Owusu-Bempah, 1994; Fernando, 2010; Patel et al., 2000; Richards, 1997). Change of any sort is often difficult for an array of reasons (see Kuhn,1962), and as the discipline of organisational development shows (Handy,1976).

### **Training of psychiatrists/psychologists in relation to issues of culture and race**

The need for all clinicians to be fully cognisant with issues relating to race, culture and diversity within mental health and to use these in their daily clinical practice is a core skill and requirement. The issue of diversity and difference is one that affects all of us, every day of our lives and in many ways (Lane & Tribe, 2010). Diversity which is visible and invisible needs to be actively considered, not only in the clinical encounter but also in how these may impact upon the individual, societal constructs of diversity in all its forms and in how service provision is set up (Shankar, 2013). Every individual is unique and carries within them a personal culture and belief system. Whilst there may be similarities across culture and/or religion, culture is multi-layered, individual, nuanced, complex and to some degree fluid (Tribe, 2011). Culture is not a monolithic or unitary entity which is dictated by the place of our birth, although our place of birth and subsequent country of residence may play a role, as may ethnicity, race and religious or spiritual beliefs (Fernando, 2010; Lago, 2011). Fernando (2006 :1) writes that cultures are never static, arguing that, "They are dynamic living systems continually changing. So a culturally diverse society may (for convenience and short hand) recognise 'cultural groups', but the reality is that the society as a whole is culturally hybrid or mixed". For example, culture changes over time as new ideas, values, technologies and influences develop, and as people have more influences upon them (Senior & Fleming, 2006). These changes may be further mediated by familial beliefs, individual experiences throughout our lives, and our interpretation of these.

The International Organisation for Migration (IOM) (2012) states that one in every thirty three people in the world is classified as a migrant. The term migrant is itself highly politicized as are some associated terms and definitions may be used differently and on occasions rather loosely. The Migration observatory at Oxford University states that in 2011, the UK population contained 12.3% residents who were born in other countries (up from 7.3% in 1993), with London hosting 2.6 million people who were born in other countries. Worldwide there are over 215 million international migrants (World Bank, 2011). Issues of diversity, race and culture are important regardless of place of birth, as racism and bad practice do not differentiate between recently arrived migrants and long established British BAME individuals and communities, but these figures may provide some contextual information. Thus all clinicians need to be trained to think about how issues of diversity, race and culture are present in their work if they are to be effective practitioners who can work with the entire population. The best place for this to start is as a central part of their qualification training. The seminal work of Suman Fernando in bringing the specific issues of race, culture and accessible and appropriate services to the fore within Mental Health is to be commended, and the influence of his work will be considered throughout this chapter in relation to his practice and work.

All professional bodies operating within mental health state that they support equality of access and require competencies in working effectively across cultures. The Royal College of Psychiatrists has a Race equality action plan (2004 :3) which states the importance of “Ensuring that psychiatric training equips psychiatrists to be culturally sensitive and culturally competent in their therapies... ensuring equal access to services for all black and ethnic minority communities, continuing dialogue with all relevant user groups, including black user groups... promoting racial equality”. Whilst the British Psychological Society in their plan for equality and diversity (2008) (currently under review) states “Our experience as psychologists who teach, research or practise

shows that we must take account of factors such as people's ethnicity, gender and age" (BPS, 2008:2 ). The BPS Division of Clinical Psychology faculty of Race & Culture faculty has as part of its mission statement "To ensure that services are relevant and accessible to people from BME communities,... Psychologists... working to advance the development of inclusive and meaningful knowledge and practice with and for ethnically diverse communities" (1). The importance of race and culture being foregrounded in training and service provision is therefore recognized at least in theory by professional bodies, if the reality or experiences of this are sometimes less evident on the ground and in service provision in various areas (Fernando, 2010; Newland & Patel, 2013).

This chapter will next look at how some of the ideas developed in western psychology and psychiatry may have limited utility when used by clinicians working in multi ethnic societies or applied to varied cultural contexts as they fail to account for cultural and racial diversity adequately (Kleinman, 1999; Marsella, 2011; Patel et al., 2000; Tribe, 2007). The disciplines of psychology and psychiatry have often failed to consider the ethno- centricism of their theories, many of which were developed from research conducted in the west, or if in other cultures, the concepts and psychometrics used were those developed and located in western psychiatry and psychology with little regard to diverse cultures and contexts (Fernando, 2010; Summerfield, 2012; Tribe, 2007). Marsella (2011) claims that " Under the illusion of "good intentions" dominant populations in charge of mental health services see their goal as preparing the ethno-cultural patient to accept, adopt and live according to the dominant group's standards of normality and expectation... must be reconsidered since they seek to homogenize diversity and in doing so, destroy critical ethnic identity resources. Emphasis upon using dominant culture norms and expectations can distort, deny hide or contribute to patient problems, and interfere with the service needs of minority and marginalized groups" (section 12).

Evidence of this may be found in the fact that the use of mental health services by people from British and Asian Minority Ethnic (BAME) communities is reported to be less than the rest of the population (Bhugra & Gupta, 2011), which is a grave cause for concern. The reasons given for this discrepancy are many and have included racism, stigma, poor accessibility, attempts to standardise patients to fit a pre conceived view based on western 'norms', lack of appropriateness, a failure to understand cultural diversity, and language differences (Fernando, 2010; Mental Health Foundation, 2012). Whilst diverse explanatory health beliefs and idioms of distress also require consideration, if mental health services are going to be appropriate and accessible to everyone (Tribe, 2005). Bhui et al. (2003) in a systematic review found that black patients had more complex pathways to specialist care, and that there were a series of issues which require attention. Politics and media influences may also play a role, as will any prevailing current or historic discourses about mental health, as well as issues of culture and race. It was argued (Addley et al., 2011) that some of the media coverage of the 2010 UK riots took a particular perspective on race, and was presented in such a way as to give the impression that the rioters were mostly black, which was not the case.

The issues of culture, race and mental health or well-being have a developing literature. Suman Fernando has been a leading writer and theorist in this area. In addition to this he has been an erudite and critical voice of the global mental health movement whom he accuses of using an inappropriate and contested western framework which fails to account for local knowledge and perspectives, in addition to trying to medicalise distress around the world and to colonise other knowledge bases (Fernando, 2013).

## **Current Training Issues**

Taking a holistic approach which considers the socio-cultural and historical context from which western psychological theory emanates and is still embedded, is sometimes strangely absent from psychiatric and psychological training. Several theorists have claimed that psychological theory is eurocentric (see Howitt & Owusu-Bempah, 1994; Richards, 1997; while others have claimed it can be racist (Patel & Newland, 2014). Prilleltensky (2002) among many other theorists has argued for mental health professionals to consider the context and experience of service users. The recovery agenda has assisted with this and the importance of the context and experiences which frame and define an individual's life are being recognised by some mental health professionals and training programmes. The notion of globalisation in the literature and the media has been discussed, although this often means western notions being dominant over others (Sacks, 2003). Also, mental health practitioners are likely to be influenced by their professional culture, so adding another variable into how they conceptualise psychological distress and ways of addressing it. Thus culture and related conceptions of mental health may be multi-faceted and complex.

That some service users have been subject to racism is worryingly absent from much of the literature (Newland & Patel, 2014). The faculty of Race & Culture of the British Psychological Society were concerned about service provision for members of BAME communities and about the teaching on issues of race and culture in professional training for psychologists and produced a book entitled *Clinical Psychology: 'Race' and Culture: A Training Manual* (Patel et al., 2000). A new edition is currently under discussion. The Royal College of Psychiatry's transcultural psychiatry special interest group has also undertaken a range of work and produced resources.

### **The connection between culture and psychological knowledge**

Considering diversity and culture in relation to mental health and well-being has particular resonance as it will affect our world view and influence our perceptions and views of good mental health and ways of dealing with difficulties (Bhugra & Gupta, 2011; Bhui & Black, 2011). For example, notions of individualism or collectivism, family values, views of the self and issues of heritage all need to be considered by clinicians and commissioners of mental health services (Lago, 2011). Also, race, culture and ethnicity should not be un-critically conflated. Self definition is the most appropriate. People from a single ethnic group or country may have very different cultures, and the terms can be used in over simplified ways or based on out dated and inaccurate stereotypes. For example, whereas ethnicity has often been taken as signifying an allegiance to the 'culture of origin or heritage', in reality it can be highly individual, entail issues of choice which may also have been mediated by other variables. In addition it has sometimes been used in a pejorative way to define difference, in that ethnicity is seen as a 'difference', assuming that 'the other' is the norm (Fernando, 1991).

### **Critique of Western Psychological Theory**

Western psychological and cultural theory contains a number of assumptions which include an acceptance of Cartesian dualism, (Foster, 1996; Paechter, 2004, ) which sees body and mind as separate, and leads to the division or specialisms of mental and physical health rather than an integration of the two as seen in many countries, (Watters, 2001; Tribe, 2007). Psychologists and psychiatrists trained in the west may pay little attention to service users who present with physical manifestations of their distress, other than interpreting it as a form of somatisation and dealing with it accordingly. Krause (1991 & 1994) favours a more nuanced consideration of this, and argues that existential, physical, psychological and social references all make up cultural understandings of illness and body: mind divisions, whilst Maclachlan (2006)

has written of the role of illness in conveying personal or social distress. While Fernando (2010) has repeatedly noted the over-medicalisation and social construction of distress or mental illness. He writes "Complex human problems (dealt with in other cultural settings as issues of philosophy, spirituality, ethics and so on) were constructed in western culture as medical illnesses, and then elaborated through observations from the basic sciences etc"( Fernando, 2006:1).

Perhaps of most importance is remembering that mental health should not be reified, and that there will be elements of cultural and social construction contained within any definition (Fernando, 2010; Kleinman et al., 1991). For example, psychological theories developed in the west tend to take the individual as the unit of analysis, emphasising individuality rather than collectivity. The transfer of western psychological ideas uncritically and their generalisation to the wider world can unthinkingly undermine the rich traditions and cultural heritage of low- and middle-income countries.

The uncritical application of western psychological theory can be further complicated by income and power differentials, when low and middle income countries are often offered western psychiatric/psychological expertise or help, particularly following a natural or man-made disaster. People may wish to accept this help given the tragedy of the disaster or traumatic event which has befallen their country or region, but the content of this help, which they may on occasions feel powerless to question, may be entirely inappropriate (Ganesan, 2011). For example, after the South Asian tsunami, many people took it upon themselves to jet into the affected countries to 'help', without attempting to work within the community or governmental structures which had been set up, thereby inadvertently undermining them rather than working in partnership and being accountable to local agencies and people (Tsunami evaluation coalition, 2006). These individuals sometimes ignored both the cultural frameworks



and organisational systems for co-ordination which were in place as well as uncritically bringing their own conceptual frameworks to people who had lived through a natural disaster. That is not to say that the help offered was not genuine, but that people or agencies offering it sometimes overlooked the limitations of their western models or failed to recognise the local models and systems. This un-thinking imposition of western psychology and the assumptions that this is the best or only model to assist individuals and communities can be viewed as a form of neo-colonialism (Summerfield, 2012).

Differences in culture, language, religious or spiritual beliefs are often downplayed or ignored by those from high income or powerful countries, being often wrapped up in such comments as 'being colour blind' or the assumptions that the models and ways of thinking, theory and practice are generalisable. This can be exacerbated by geo-politics, the western media and the policies of some aid agencies, this may be detrimental and undermining to individuals, families and communities. After the tsunami, the tsunami evaluation coalition (2006) stated that the current system "... produces an uneven and inequitable flow of funds for emergencies that encourages neither investment in capacity nor responses that are proportionate to need, and despite some donors' commitment to the principles of "Good Humanitarian Donorship (GHD). donors often took funding decisions based on political calculation and media pressure" There are a range of good practice guidelines and initiatives available for humanitarian agencies working in disasters in cultures very different to their own (ICAS, 2007; Nato, 2008), although there are apparently inadequate sanctions for agencies or individuals which fail to adhere to these protocols (Cosgrove, 2007).

Some of the ideas developed in western psychology and psychiatry may or may not be relevant and helpful but should be considered in conjunction with local practice and traditions (for a discussion of health pluralism see Tribe, 2007). On occasions lip

service is paid to culture, but it is seldom viewed as a central organising concept in any partnership. The notion of health pluralism, offering a diverse range of explanatory health beliefs, idioms of distress, varieties of coping strategies or help-seeking behaviours, may be most appropriate. Most cultures embody this multiplicity, though some perspectives may be viewed or valued as more powerful or dominant by different groups. There may be a varied range of designated healers or helpers. For examples relevant to Sri Lanka, the country of Suman Fernando's birth, see Somasundaram and Sivayokan 2000; Fernando, 2011; Lawrence, 1997. Working in partnership with these systems and viewing them as important resources rather than a 'necessary nuisance' or 'add-ons' to a western way of working, is essential. This may well be more appropriate in assisting individuals and communities than western models of individual trauma diagnosis and therapy. These systems often have long histories and are the preferred and familiar option for many people. They can be undermined by an uncritical reliance on western methods and assumptions about shared explanatory health beliefs and idioms of distress, from which they may differ markedly. In addition, people identified as healers are not always those to whom this role would be ascribed in a western context (Lawrence, 1997; Sax et al., 2010). Priests and indigenous healers, local rituals and traditions have an important role in assisting people deal with psychological distress in most countries in the world, though the emphasis on this may vary.

### **Collaboration between Service Users and Service Providers**

Research and best practice guidelines have begun to emerge to encourage service providers to develop services in collaboration and engagement with service users in the UK (Royal College of Psychiatrists, 2013), as well as the communities they serve (NICE guidelines, 2008). The National Institute for Health and Clinical Excellence (NICE) guideline on Community Engagement to Improve Health (NICE, 2008) details the

importance of community engagement and development .The community guidance is to be reviewed in 2014 following NIHR funded research and the impact of community engagement approaches used in the New Deal For Communities. It is hoped that these guidelines might start to lead to more appropriate and accessible services, and to an improved sense of inclusivity and ownership, although as stated earlier, guidelines and policy documents do not always lead to changes in practice. Real community engagement offers the opportunity to those commissioning services and service providers to develop in a dynamic way based on need, and in line with any changes in the population as well as the requirements of the complete community which will include a range of cultures and races.

## **Conclusion**

We need to remain vigilant and reflective to ensure that issues of diversity, race and culture are fore-grounded in our training institutions and in clinical practice if we are to ensure that mental health services are accessible and appropriate to the entire population in the future. There are a range of policy documents written by the major professional bodies (RCP and BPS) and at the national level (NICE guidelines) which stress the need to consider issues of diversity, race and culture and to listen to service users from BAME communities, but unfortunately trainees' experiences, clinical practice, pathways to care and service usage does not always reflect the requirements of these documents. The western Ethno centricism of much of psychology and psychiatric theory is often taught uncritically which can mean that the status quo remains and changes are not implemented which stress the importance of race, culture and diversity despite the work of Suman Fernando and others. The innovative work of Suman Fernando in raising these issues throughout his career in the UK and around the world is impressive. He has consistently raised these issues through his publications

and talks to a wide range of audiences. He has also been an example of a consistent and dedicated academic and clinician writing about the importance of considering and valuing the rich sources of support and meaning in relation to wellbeing and health found in most cultures and how conventional cultural wisdom can be undermined by an insistence on applying western ideas uncritically. In summary, the work of Suman Fernando in the UK, Sri Lanka and around the world shows the enormous scope and influence of his work on both theory and practice within a range of domains within mental health. The impact of his most recent work may also be yet to be felt.

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