Caring for people from diverse cultures

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Introduction

- Culture
- In Australia
- Health beliefs
- Stigma and acculturation
- The Westernization of mental health
- Our roles

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Culture

- … 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 share sayings, legions, literature, art, diet, costume, religion, making preferences, child-rearing practices, entertainment, recreation, philosophical thought, and government. (Sadock & Sadock, 2007)

Culture

- Whether the group is an ethnic group or group of people with a common set of beliefs their culture is their worldview.
- Much of culture is learned unconsciously through interaction with others in the cultural group.
- Because cultural values are largely unconscious, expectations of other peoples' behaviour are also.
- Our reaction to other people breaching those expectations tend to be emotional, and judgmental. For example: making eye contact.
- Ethnocentrism and symbols
- Stereotypes

In Australia

- Since 1945 7 million people have migrated to Australia, 25% of all Australians were born OS
- In 2014 Australia received 203,900 immigrants
- The top 10 countries of birth of permanent: UK; NZ; India; China (excluding Hong Kong, Macau and Taiwan); South Africa; Philippines; Malaysia; Korea; Sri Lanka; Thailand comprising 66% of the total.
- The remaining 34% of permanent settlers were born in over 190 other countries.
- Between 1996 and 2008, almost 116,000 people from Africa permanently settled in Australia (plus almost 2 million others)
- By 2026 one in four people in Australia aged 70 years and over will be from a CALD background.
- Australia has resettled over 700,000 refugees and humanitarian migrants since 1945 and resettles more than 14,000 refugees yearly.

Health beliefs

- The impact of external forces (weather, spirits or supernatural forces, karma, or luck).
- Collective Vs individual.
- 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).
- There relationship between mental health and physical health.

Health beliefs

- Yin and yang: (male /female).
- Hot and Cold
- Health may be attributed to good luck or to leading a good life, (past or present)
- Illness caused by evil spirits or exposure to polluting sources
- Possession by a demon, or the “evil eye”.
- Wind (or air) and Water:
- Ghost possession.
- Sorcery.

Treatments

- Illness may be treated by:
- Tiger Balm
- Tonics, such as ginseng
- Coining
- A cloth wrapped around the abdomen
- Herbal medicine.
- Acupuncture
- Moxibustion
- Ayurvedic medicine
- Cupping

Stigma and Acculturation

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, stereotypy and discrimination (Ng, 1997).

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Stigma and Acculturation

- Stigma affects symptom expression, self-disclosure and service utilization
  - Somatization
  - Denial
  - Underutilization of services

Torture and trauma survivors and refugees

- There is a correlation between trauma and PTSD, anxiety and major depression
- Trauma is cumulative
- Refugee camp and detention centre experiences compound mental health problems
- Post-migration factors (host country discrimination, isolation and loneliness, unemployment and detachment of ethnic enclaves)
- Mental health might improve over time
- Religion and gender might mitigate the effects

Dual vulnerabilities

- Cultural and linguistic diversity
- Mental illness

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Westernization

- Australian mental heath services are based on Anglo-Celtic belief systems and Western cultural norms
- The effects of the Diagnostic and Statistical Manual on the homogenization and simplification of mental illness
  - Naming something does not explain it (the platypus and human behaviour)
  - The debate about psychiatric classification and its consequences is not new and has generally revolved around description versus aetiology.
  - The danger with an emphasis on description is that it may leave little room for the interpretation of psychopathology. In addition if the descriptions are drawn from one dominant cultural perspective then from the beginning their cross-cultural universality should be questioned. In such a system, the manifestations of mental illness may be forced to fit preconceived frameworks and paradoxically the zeal for classification may see more and more human behaviour pathologized.

The DSM

- Now in its fifth edition
- Between 1952 and 2015 diagnoses rose 800% (106->600)
- It is translated into more than 22 languages
- According to Gary Greenberg (2010, p.15) *"the DSM is an unparalleled literary achievement. It renders the varieties of our psychospiritual suffering without any comment on where it comes from, what it means, or what ought to be done about it".*

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Criticisms

- The imposition of a North American/Western European perspective on mental illness and the relegation of other cultural perspectives to curiosity status (An appendix called “culture-bound syndromes”)
- The mistake of thinking we are describing stable entities when what are really being described are also socio-political constructs.
- It further assumes the universality of its primary syndromes. The socio-political construction of the DSM, even within its own cultural paradigm, is well illustrated by the fact that the mental disorder of homosexuality was cured with a stroke of a pen when it was eliminated from the DSM II in 1974.
- It all coincides with the rise of the biomedical model of care and “big pharma”

Criticisms

- Disruptive Mood Dysregulation Disorder, for temper tantrums
- Major Depressive Disorder, includes normal grief
- Minor Neurocognitive Disorder, for normal forgetting in old age
- Adult Attention Deficit Disorder, encouraging psychiatric prescriptions of stimulants
- Binge Eating Disorder, for excessive eating
- First time drug users will be lumped in with addicts
- Behavioral Addictions, making a "mental disorder of everything we like to do a lot."
- Generalized Anxiety Disorder, includes everyday worries (Frances 2012)

Our roles

Respect for cultural differences and acknowledge diversity (attitudes, values & behaviours

Demonstrate cultural understanding (not competence) but avoid stereotyping

Use appropriate resources and seek the help of experts

Multiple world views (clinicians, consumers, health systems)

Sharing a world-view and ethnic similarity

Being credible: therapeutic alliance, shared world views, acknowledge consumer and carer expectations, mutual decision-making

Use translated standardized instruments whenever possible

Use non-standard methods such as journaling to uncover the story

Use the DMS with care

Explore the consumer and carer's frame of reference

Explain everything thoroughly

Extend your boundaries

Extending our boundaries

- *How do we ensure that we meet consumer and carer needs, if they have some barriers to communicating those needs?*
- The effectiveness of intercultural and interpersonal communication between members of different cultures, races or ethnic groups impacts upon an individual's willingness to self-disclose and seek help. Self-disclosing to a stranger in a foreign and often frightening situation, such as when a person is seeking professional help for mental illness requires effective interpersonal skills and understanding on behalf of the mental health clinician.
- Many migrants are "linguistically isolated" and rely on family/community members to speak for them, however the use of non-professional interpreters in the mental health setting, is problematic and leads to a communication errors, misdiagnosis and role conflict, and therefore, they should be used with caution.

Extending our boundaries

- Although mental health clinicians may have little or no formal cross-cultural training, they attempt with remarkable success to respect and understand the individual needs of their clients, extending cultural boundaries, and being open to other cultural and ethnic practices.
- We conducted a study, with 53 mental health clinicians from both community and inpatient settings, that explored the mechanisms they used to bridge cultural differences and engage with CALD consumers and carers. Two distinct themes emerged. They were ‘respect’ and ‘cultural understanding’.

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Respect

All clinicians reported various ways in which they attempted to demonstrate their respect for the consumer and their culture. They recognised that their appearance and behaviours could communicate respect and encourage disclosure. They also described following the lead of other family members to determine the appropriate person for communication and found that addressing the right person in the family helped consumers and their families to disclose information and opinions more readily.

- Respect for language differences and encouraging the use of professional interpreters, particularly in the early stages of establishing a relationship with the consumer and family, minimized some of the problems associated with cross cultural assessment, treatment and care and aided communication. The clinicians also commented that interpreters "*…often tell you things that you didn't know that's going on in the house".* They preferred to work without an interpreter once a level of communication and trust had been established.

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Respect

- It was also important to understand the family structure, in particular, knowing who the important family members were.
- *What you do is you address who seems to be the head of the family and you usually don't say much until you work out who's the head of the family; and even though they don't speak English you just have to make some sort of acknowledgment.*
- Cultural gender differences were also discussed. This sometimes meant that same-sex clinicians were essential for disclosure. Depending on the nature of the issue, for example, sexual assault or abuse, female clinicians were preferred. A male clinician commented
- *In some cases I have to talk to the woman's husband or father. This makes it really difficult because I can never really know what the woman is thinking and what she would tell me if she had the choice.*
- Nevertheless they understood the place of trust in the relationship and the effort that is sometimes required to develop it for the benefit of the consumer.

Cultural Understanding

- Clinicians described how they took great pains to understand their consumers and their cultural beliefs, an essential skill as consumers disclosed their distress in culturally contextual ways.
- They recounted how consumers and their families perceived them to be more credible when they apologised for their ignorance, showed a willingness to learn, and make exceptions out of respect for the consumer's and family's culture. This credibility seemed to enhance the feeling of hope and the sense of getting better for the client.
- *I found that the people who are most accepting are people who think you've done something for them. I can remember once being called out. An Asian fellow who [was psychotic] and he of course came with me and ever since then the parents were quite grateful....they were much more open than they had been previously so I think they could see that I was on their side.*

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Cultural Understanding

- The clinicians in this study went to extraordinary lengths, and showed remarkable commitment to facilitate intercultural communication and interact appropriately with their clients from many distinct cultural groups, speaking many divergent languages and dialects.
- They showed great respect for cultural differences and special needs and at the same time worked within the constraints of the service delivery system.

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Conclusion

- Our beliefs, morals, customs, 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 be the same. 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 people are not disadvantaged by our practices.