Master Classes
Mental Health, ‘Race’ and Culture

2. Critical Psychiatry & Psychology
Cultural Psychiatry, Anti-racist Psychiatry
PROBLEMS OF BEING CULTURALLY SENSITIVE

Psychology and psychiatry are socially constructed processes located in a specific cultural tradition, representing particular ideas about the human condition.

Aims of therapy are culturally determined.

Judgements are influenced by racist assumptions, stereotypes and biases in ‘common-sense’.

The role of a professional in compulsory detention and in forensic psychiatry is more about social control than about care or therapy.
INSTITUTIONAL RACISM

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

*The Stephen Lawrence Inquiry* by Sir William Macpherson (Home Department, 1999:28)
‘BLACKWOOD INQUIRY’ REPORT 1993

POINTS HIGHLIGHTED INCLUDE

Subtle racism in the forensic psychiatric system
(e.g. stereotype of ‘big black and dangerous’)

Need for:

- dealing with racism in forensic system
- ethnic monitoring of medication levels
- training in control and restraint
- monitoring patterns of diagnosis in BME patients

RACIAL AND CULTURAL ISSUES
FINDINGS IN ENGLAND

*Black / Ethnic Minorities more often:*

- Diagnosed as schizophrenic
- Compulsorily detained under M.H.Act
- Admitted as ‘Offender Patients’
- Held by police under S. 136 of M.H.Act
- Transferred to locked wards
- Not referred for ‘talking therapies’

IMPEDIMENTS TO CHANGE

Dynamic conservatism in institutions (Schon, 1971)
good intentions but no implementation

Diagnosis as dogma
‘useful framework’ (Kendell and Jablensky, 2003)

Language of ‘culture’
‘cultural sensitivity’ instead of ‘anti-racism’

References


Training in Transcultural Psychiatry

KNOWLEDGE
Non-western health belief systems
Cultural diversity in construction of identity
Understanding ‘race’, racism, culture and ethnicity

SKILLS
Relating to people of various cultural backgrounds
Dealing with racism at personal and institutional levels
Managing uncertainly while exploring ‘other’ worldviews
Acquiring culture-specific knowledge
Negotiating therapeutic approaches in cross-cultural settings

ATTITUDES
Humility in acknowledging limitations of psychiatry
Appreciating power imbalances
Curiosity about cultural differences
Sensitivity to value of critical feedback

Ref:
Based on workshop at Royal College of Psychiatrists February 2001
Transcultural / Cultural Psychiatry

1. Mental health and mental illness seen differently in different traditions
   All are equally valid

2. Cultures are not fixed but dynamic, constantly changing
   No ‘pure’ tradition except in very isolated groups of people

3. Psychiatry is located in Western post-enlightenment tradition
   Models of ‘illness’ and ‘normality’
   Underlying concept of human condition
   Largely bio-medical approach to ‘illness’

4. Application of psychiatry in non-western settings
   Should address local conditions, beliefs systems etc.
   Services need to be ‘home-grown’ taking account of how mental health and
   illness are conceptualised locally

5. Application of bio-medical psychiatry in multicultural (western\non-western) societies
   Should use flexible systems of assessment taking account of politics, power
   positions, racism, stereotyping etc. AND use variety of therapies, taking account of
   values, worldviews, beliefs, culturally acceptable healing practices, etc.

Diagnostic Misperceptions involving ‘race’ and ‘culture’

Because of

Cultural dissonance (‘culture-clash’) between psychiatry and background of clients

Assumption of ‘objectivity’ of diagnosis and certainty of western cultural thinking

Political pressures to put away people considered ‘dangerous’ to ensure public safety

Institutional racism, especially influence of stereotypes in clinical judgement

racist perceptions of ‘psychosis’, ‘schizophrenia’, and dangerousness

Disregard of service-user perceptions of ‘problems’ and diversity in expression of distress and anger

MACHINERY OF PSYCHIATRY IN CONTEXT

Clinical Observations  →  Traditions  →  Basic Sciences  →  Empirical Observations

Categories

Generalisations, Typifications, etc

Stereotypes

Common Sense

Popular Stereotypes

European Culture

Ideologies  →  Assumptions

Social and Political Forces

DIAGNOSES  →  TREATMENT

CULTURE OF PSYCHIATRY

PSYCHIATRIC DIAGNOSES

Not objective facts but hypotheses that may or may not be useful

Distinction between ‘mental’ and most physical illnesses

Usefulness rather than validity is what matters in mental health matters

References
CONCEPT OF ‘SCHIZOPHRENIA’
Will it last?

CONSTRUCTED IN 1890s – 1920s IN GERMANY (Kraepelin, Bleuler)
SPREAD TO REST OF EUROPE / WORLD (‘psychiatric imperialism’)
CONTEXT OF RACIST IDEOLOGIES (e.g. degeneration Morel (1852) -see Pick, 1989)
CONTEXT OF CULTURAL BLINDNESS (i.e. observations in Europe only)

NOW
NO LONGER USEFUL IN RESEARCH
MASSIVE INVESTMENT IN MAINTAINING CONCEPT (e.g. selling drugs for its ‘control’)
OPPRESSIVE AND RACIST IN PRACTICE
MISLEADING AS ‘ILLNESS’

FUTURE?
SHIFT TO SYMPTOM APPROACH?
REPLACE WITH ‘PROBLEM’ APPROACH?
MOVE TO DIMENSIONAL APPROACH

References
Morel, B. A. (1852) Traites des Mentales (Paris: Masson)

CROSS-CULTURAL VARIATION OF DEPRESSION

• PRIMARY DISTURBANCE IS SENSE OF FAILURE OR LOSS EXPERIENCED IN CONTEXT OF DIFFERENTIATION OF ‘SELF’ vs. ‘OTHER’
  – Loss of group membership = ‘ISOLATION’
  – Failure towards others = ‘SHAME’
  – Failure towards oneself = ‘GUILT’
    – (Murphy, 1973)

• ‘DEPRESSION’ OCCURS IN CULTURES THAT ‘PSYCHOLOGIZE’ EXPERIENCE
  – (Marsella, 1978)

• DEPRESSION IS AN ILLNESS IN CULTURES WHERE ‘DEPRESSIVE AFFECTS’ ARE FREE- FLOATING AND NOT TIED TO ISSUES OF EXISTENCE / RELIGION
  – (Obeyesekere, 1985)
Diagnosis, loss of liberty and compulsory treatment

Early 20th Century
Legal safeguards developed around action permitted for ‘lunacy’, ‘certification’ and humane ‘treatment’

Late 20th Century
Developing services for ‘mental health’
Liberalisation of legal frameworks
Tightening of definition of ‘mental disorder’
*But* 1990’s onwards increasing controls ?reversal of liberalisation

21st Century (especially 2007 MH Act)
Compulsory treatment in the community
‘Safety of public’ given precedence over treatability
‘Personality Disorder’ becomes an illness for indefinite custody
MENTAL HEALTH FOR ALL 1

Shift in diagnostic system / assessment

Re-defining ‘illness’ within ethical limitations of concepts / move away from Kraepelin
open to concepts from non-western cultural traditions
(variety of psychologies)
A new cross-cultural psychology
(combination of ‘the experiential, holistic, and
enlightenment-oriented traditions of the East with the precision, clarity, skepticism, and independence of Western methods’ (Welwood, 1979)

References
MENTAL HEALTH FOR ALL 2

Assessing ‘symptoms’ and ‘mental state’

- Identify (culturally diverse) idioms of distress
- Identify coping (survival) strategies to counteract racism
- Examine ‘paranoia’ in light of social realities
- Recognise ‘healthy cultural paranoia’ (Grier & Cobbs, 1969)
- Deconstruct ‘schizophrenia’ into ‘symptoms’
- Variety of interpretations of ‘depression’

References
MENTAL HEALTH FOR ALL 3

Widen scope of ‘treatment’

- Social networks – community based support
- Coping strategies to deal with systems of oppression (e.g. racism)
- Spiritual practices
- ‘Alternative therapies’
- Pragmatic use of medication

MENTAL HEALTH FOR ALL 4

Re-structuring systems of ‘care’

• Legal system promoting ‘treatment’ not custody
  separate risk assessment from mental ‘illness’

• Cultural understanding replace individual diagnosis
  ‘multi-systems approach’ (Boyd-Franklin and Shenouda, 1990)

• User-choice within a wide range of support services
  Choice and partnership (CAPA) (York and Kingsbury, 2009)

References
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