



TRANS-CULTURAL CARE IN MENTAL HEALTH

RUTH DESOUZA

OCTOBER
WHIRINGA A NUKU
अक्टूबर
1996

Presented at the Australian and New Zealand Conference of Mental Health Nurses Annual Conference,
Auckland, Aotearoa - New Zealand.

Abstract

In 1995 I commenced a Graduate Diploma in Counselling. In the process of writing assignments for this course several issues arose around culture and cultural differences, namely —

- Is it relevant, or even preferable, for Mental Health workers to be of the same ethnic group as their client?
- What factors prevent ethnic minorities from availing themselves of the services provided by Mental Health practitioners?
- What strategies can Mental Health practitioners use to enhance their care, support and understanding of migrants, their communities, beliefs and traditions?

As a Mental Health practitioner — both institutional and in the community, in Aotearoa-New Zealand and overseas — and an immigrant to Aotearoa-New Zealand, I have gained a broad perspective of the issues of ethnicity within the Mental Health system. In this paper I will attempt to stimulate discussion about these issues in this context and that of Maternal Mental Health.

Ruth DeSouza

October 1996.

Introduction

Mental Health Nursing is about people, people of all races, cultures, socioeconomic groups and walks of life. So it follows that to provide quality care we must acknowledge the lived experiences of our clients, how these shape their beliefs and the acceptability of treatments. To provide quality care we must acknowledge cultural diversity. A system that does not take into account or even which denies consideration of race, culture, gender or social values does not serve the people it purports to (Speight 1991). As professionals we need to be able to work with everyone (Kareem and Littlewood 1992).

Services must be accessible to all regardless of their culture and colour. However, we should not under-estimate the effort involved in achieving this. For example, psychiatric nurses can be viewed by some as agents of social control (Wright 1991). We need to develop practical and realistic ways of supporting those whose cultural roots are different from our own, thus avoiding “projecting our own cultural expectations under the guise of therapeutic interventions” (Wright 1991).

In examining my own effectiveness as a psychiatric nurse two important experiences have become apparent. Firstly, being an immigrant and secondly living in a country where I belong to a minority culture. I, therefore, find myself a cross-cultural counsellor, pre-dominantly of people outside my own ethnicity (Sue 1990).

Putting Culture In Context

Culture is one of the lenses through which individuals perceive the world. Others include age, gender, size, education, religion, socio-economic background and status (McAvoy 1990). Therefore, culture is but one ingredient in the complex recipe that makes up an individual. Within a culture many variations, or sub-cultures, will often exist (McAvoy 1990). For example, I am from Goa, which although part of India has a very distinct and unique flavour. Further to this, I was born in Africa. This gives me, and others like me, a different perspective to those who have been born and brought up in Goa.

Cultural Misuse

The concept of culture can also be misused (McAvoy 1990) —

- Cultures need to be considered in their existing context, so issues like social class and economic status are also important.
- It is useful to consider the culture of the majority, as its tolerance or xenophobia impacts on the ability of the minority to access resources.

- Differences within a cultural group may be as relevant as those that exist between cultures. For example, I was involved in an Indian women's group, where we had being Indian in common. Our differences were that members of the group were born in India, Tanzania, Fiji and Aotearoa-New Zealand. We were of different religions, occupations, castes, ages, educations and socio-economic groups.
- There may not be a "pure" culture. Cultures can be affected by many things, including the media, travel and education, and may be combined with the host culture as a group assimilates.

Migration And Mental Health

Studies have shown that in addition to the common stresses that all people experience, minorities also encounter additional unique stresses such as prejudice, poverty and racism (Sue 1990). Ferguson and Browne (Ferguson 1991) suggest that factors affecting migrants and their mental health include the following:

- Their previous personality, emotional health and coping mechanisms.
- Stress of migration.
- Bereavement aspects of the migration process.
- Reception and ease of settlement into the host country.
- Support measures available and size of the ethnic community.
- Cultural differences between the country of origin and the adopted country.
- Acceptability and availability of the adopted countries' services.
- Social class, including under-employment and unemployment.
- Discrimination and racism.

What Prevents Minorities From Using Mental Health Services?

I am presently working in the area of Maternal Mental Health. Childbirth ranks highly on a scale of life events and is one of the most dramatic developmental stages in a person's life (Gruen 1990). In addition, the losses and changes of motherhood include the loss of past identity and way of life. Adjusting to taking care of a tiny, unpredictable human being and having one's own needs put in

second place is required. Separation from networks and family, ignorance about babies, grief over childhood, youth and freedom and own need of mothering would lead one to think that minority women would be more predisposed to developing Post Natal Depression (PND). Furthermore, the difficulties in navigating a hostile and everchanging health system, the vulnerability of being isolated by culture, compounded by an inability or decreased ability to speak English should result in queues to our service. However, this is not the case as seen by the tiny number of minority women seen in the twelve months that our service has been offered.

More investigation into the incidence of PND in minorities and immigrants in Aotearoa-New Zealand is required. This population appears to be additionally disadvantaged in terms of accessing health services, being separated from family networks and traditional birth practices. In a study by Webster (Webster 1994) et al the Edinburgh Post natal Depression Scale (EPDS) scores of five women of Asian and Pacific island ethnicity were discarded because their scores could not be validated in a clinical interview due to language difficulties. This has implications on the efficacy and validity of the EPDS as a widely used screening tool in clinical practise.

There are a number of factors which could prevent minority clients using services —

Service Delivery

Sue & Sue (Sue 1990) suggest that the reasons minority groups underutilise services lie in the systems biased nature, which are insensitive, antagonistic and discriminating. They suggest that this is related to the training of mental health professionals which is biased toward a white, middle class perspective. A person who is not verbal or speaks with an accent may be at a disadvantage particularly if there are no bilingual staff. The qualities valued by mental health services may be an area of clash, for example self-disclosure, insight and self responsibility.

Model Used

Most forms of counselling and psychotherapy were developed from a white, middle class, American, English-speaking milieu. This has then been applied cross-culturally (Wright 1991) . The intrapsychic model that is used predominantly sees difficulties as the result of personal disorganisation, rather than in the wider context of an oppressive society. This blaming the person approach tends to deny the existence of society's ills, consequently differences are seen as deficits (Wright 1991) . A rejection of help offered by mental health services is seen as an indicator of the individuals failure to function adequately. The result is that mental health workers validate our role and function within the cross cultural relationship by blaming the victim. (Wright 1991) Wright. Instead, if we respond to the person in their cultural setting rather than just to their cultural setting we might be successful in engaging our clients (Wright 1991). There can be a great deal of stigma associated with receiving mental health services within their culture, as well as little faith in psychotherapy as a treatment option and fear of institutionalisation.

Alternative Models

The biomedical model has failed to legitimise traditional healers and networks of many communities, labelling them as supernatural and unscientific (Sue & (Sue 1990). Minority clients often prefer support from their own community (Gauntlett 1995), whether these are informal support networks or trusted folk healers, who share their beliefs about the role of religion or the supernatural, the role of the family in treatment and the context and process of treatment (Flaskerud 1984) (Flaskerud, 1984). As a child, my sleepwalking was treated by an elderly woman in our community. She diagnosed the “evil eye” and her incantations and prayers provided an immediate remedy. What would the Western system of medicine have done?

Mental health workers need to develop some openness to a compromise between conventional psychiatry and peoples cultural beliefs (Wright 1991), particularly where cultural practises are preferred, such as massage or consultation with folk healers. There needs to be a widening of our attitudes as to what constitutes legitimate mental health practises. Research into this could provide us with alternative frames of reference rather than Western definitions of mental health (Sue 1990).

Definition Of The Problem

Stern and Kruckman (Stern 1983) point out that the defining criteria for depression may vary greatly across cultures and so cannot necessarily be resolved by applying a Western concept of depression to them. Thus, the diagnosis and treatment of clients from minority cultures may be inaccurate, even discriminatory and punitive (Flaskerud 1990). The incidence of PND in the cross cultural literature suggests that it is culture bound (Howard 1993). Cultural rituals may cushion or prevent against the experience of PND regardless of whether it is due to biology or sociology. Given that there are significant differences between cultures in terms of the organisation of family structures, expectations of women and social responses to birth, it follows that there will be different rates of occurrence and associated factors (Kumar 1994).

Structural Barriers

Durvasula & Mylvaganam (Durvasula and Mylvaganam 1994) suggest that a lack of awareness or knowledge of services, where they are located and a scarcity of ethnically similar counsellors or counsellors who are bilingual provide barriers to minorities using mental health services. One attempt at solving this in the United States has seen these structural barriers reduced by creating parallel mental health services which provide ethnically responsive mental health services staffed by bilingual counsellors (Durvasula and Mylvaganam 1994). A disadvantage of these services is that mainstream services may fail to develop culturally responsive services.

Culture Matching

There are a number of interesting issues when considering matching client and therapist by culture

Enhancing The Therapeutic Relationship

Research suggests that cultural similarity facilitates self disclosure, a highly valued aspect of counselling (Jourard, 1964 cited in (Belkin 1988) . Shared experiences are also thought to facilitate or enhance rapport (Belkin 1988) . Furthermore, it is suggested that culture matching will increase the ability to understand language, nuance, communication styles and body language.

Identity And Role Models

The literature suggests that a minority client seeing a minority counsellor will be provided with a role model of someone who has made it in the majority culture (Flaskerud 1990). American studies have shown that Afro-American clients prefer Afro-American counsellors (Atkinson, 1983 cited in (Flaskerud 1990) , but that this is closely related to the clients level of racial consciousness and other variables such as their socioeconomic group. Jackson (1973 cited in (Belkin 1988) suggests that minority clients may experience anger when they encounter a counsellor from the same cultural background as themselves for reasons such as feeling that a majority counsellor would be more competent or that the counsellor is “too white” or too far removed from their roots to understand their difficulties. Other variables within the culture such as values, attitudes about mental illness and levels of acculturation may cause a mismatch (Flaskerud 1990) , accentuating the within group differences which are as significant as the differences between groups (Speight 1991) .

Issues For The Minority Counsellor

For minority counsellors, anger from minority clients can lead to defensiveness which would sabotage the therapeutic relationship (Jackson, 1973 cited in (Belkin 1988). Minority counsellors may over-identify or deny identification with the client (Gardner, 1971 cited in (Belkin 1988). A minority counsellor may see the contact with minority clients as low status work when compared to work with majority culture clients (Sattler, 1970 cited in (Belkin 1988). They can also be less tolerant and understanding of minority clients (Sattler, 1970 cited in (Belkin 1988)and assumptions may be made about a shared world view and identity (Belkin 1988).

Inter-Minority Group Counselling

There is little literature which addresses inter-minority group counselling, other than to say that there may be shared camaraderie as a result of the recognition of shared oppression (Belkin 1988).

Minority Counsellor And Majority Client

There is a paucity of research on whether a minority counsellor can effectively treat a majority client (Flaskerud 1990). One observation that has been made is to say that the client may find it easier to confide in a counsellor who is not from the establishment and who will maintain confidentiality (Jackson, 1973 cited in (Belkin 1988).

Majority Counsellor And Minority Client

The majority counsellor may interpret adaptive behaviour as pathological. For example, my upbringing in Kenya taught me to be safety conscious because my life could depend on it, this in turn could be seen as paranoid or overly anxious. A counsellors “cultural encapsulation” (Wrenn, 1962 cited in (Sue 1990) could mean that their definition of “normal” is based on a white, middle class standard (Pederson, 1976 cited in (Belkin 1988). This view sees anything outside that frame of reference as abnormal. Stereotypes may prevail or majority counsellors may appear “colourblind”, treating clients the same and not acknowledging the differences.

Matching Is Reductionist And Simplistic

Our experiences as humans is remarkably similar (Belkin 1988) . Matching done purely on the basis of race or colour can imprison both the professional and client in their own racial and cultural identity, as well as reduce individuals into solely cultural characteristics (Speight, et al, 1991). In focusing on the cultural we may forget the human aspect which is integral to our work ((Speight 1991), Kareem & Littlewood, 1992). This can be transcended by having an existential philosophy that understands human experience (Fukuyama, 1990 cited in Speight, et al, 1991). The ability to work with another individual is a basic counselling skill. The possible permutations of differences among counselling clients are infinite ((Speight 1991) and every counselling encounter is “multicultural” in some aspect (Pederson, 1988 cited in ((Speight 1991)). Must a counsellor experience everything that their client has experienced (Belkin 1988) and is it possible, or necessary, for two individuals to ever fully share the same life experiences (Belkin 1988) ?

Need For Further Discussion And Research

There needs to be further discussion and research, particularly within the Aotearoa-New Zealand context, about culture matching. Values, religion, language, life styles and so on might be alternative and more appropriate matches than culture (Flaskerud 1990);(Speight 1991) . Research has failed to demonstrate that client-therapist culture matches are more effective than non-matches to clinical outcomes (Flaskerud 1990) ; (Gottheil 1981) Gottheil, Sterling, Weinstein, Kurtz, 1994). There has been little discussion of within group differences ((Speight 1991) . Research in the United States has been contradictory about the benefits or otherwise of culture matching (Flaskerud 1990); ((Speight 1991).

Benefits Of Cross Cultural Counselling

Cross cultural counselling offers a unique opportunity for client and counsellor to know each other and their worlds, in a way that they might not outside the counselling relationship. According to Kareem (Kareem and Littlewood 1992)(1992, p 21), “ Diversity brings life, vibrancy and colour to human society”.

Strategies

Some strategies that can prove helpful are —

Individually

- Become aware of our own ethnocentrism, that is, the belief that one’s own group is superior to others (Henderson 1981) . It has been well documented that counsellors are more likely to have good relationships with clients who fit the YAVIS client-model, namely, “Young, Attractive, Verbal, Intelligent and Successful” (Schofield, 1964 cited in (Sue 1990) Sue & Sue, 1990). Clients from other cultures are often seen as having less of these qualities (D’Ardenne 1989) (D’Ardenne & Mahtani, 1989). Our ethnocentrism may be reflected back to the client, causing them to withdraw or be seen as non-compliant and resistive (D’Ardenne 1989) (D’Ardenne & Mahtani, 1989).
- Recognise that it is counterproductive to treat all people alike. There are characteristics all people share, such as need for food and shelter, characteristics that some people share, such as language, and some that are unique to a group, this includes racial or ethnic historical conditions, for example slavery (Henderson 1981).
- Avoid creating stereotypes and generalisations.
- Recognise the limitations of our own expertise and enlist the help of culturally appropriate practitioners as requested or required.
- Allow clients to define themselves rather than attempting to erase our clients lived experiences with categories, notions of dysfunction or simplistic theories (MacKinnon 1993).
- Assist clients to optimally use the services available.
- Acknowledge with the client that there is a difference of cultures and encourage the client to be your teacher of what is culturally sensitive. Use photographs, books and articles of significance. Also try using other ways of communicating, such as music, drawing or painting.
- Sharing of cultural practises is by invitation, when you experience this, acknowledge it.
- Become knowledgeable, sensitive and aware of clients in their cultural setting (Wright 1991) .

- Recognise that there is diversity within groups as well as between groups (Charonko 1992).
- Advocate for clients from ethnic minorities, particularly in regard to the way in which decisions are made in hospitals and the community (Wright 1991).

When Communicating

According to McAvoy & Donaldson (McAvoy 1990) —

- Allow plenty of time, especially if English is not a first language.
- Try and simplify information without being patronising.
- Get the clients name right and try and pronounce it properly.
- Ensure continuity and keep comprehensive notes as this prevents the client from having to repeat information.
- Write down important information for the client to keep.
- Give lots of non-verbal reassurance.
- Check for understanding by asking the client what they thought you said.
- Be careful when using slang as this can be confusing.
- Use a qualified interpreter, though this also has its drawbacks. The interpreter may leave out information or give their own advice, the client may also be nervous about issues of confidentiality, especially if from a small community. For example members of the Gujarati community are known to each other.

Environment

Acknowledge the multi-cultural nature of Aotearoa-New Zealand consumers by —

- Creating multilingual signs for welcoming and directions.
- Ensure information is available about translation services.
- Have multilingual reading material available.
- Involve the local community in the designing of the physical environment.

Education

Health professionals should —

- Be aware of the communication barriers that are presented by racism, poverty and so on.

- Develop a knowledge of minority group culture and experiences, together with developing a sensitivity to judgements and prejudices that prevent us from truly “being with” our clients (Wright 1991).
- Obtain knowledge of culturally appropriate community resources.
- Enlist the help of culturally appropriate practitioners for certain conditions.
- Be aware of alternative and holistic models of health.

Research

Nursing researchers should —

- Produce culturally unbiased nursing knowledge which facilitates progress to quality health care (Sawyer 1995) (Sawyer, Regev, Proctor, Nelson, Messias, Barnes & Meleis, 1995).
- Ensure that research participants are representative of national demographic distributions (Sawyer 1995) .
- Ensure that the researcher is an insider of the culture of the research participants (Sawyer 1995) .
- Investigate the ways particular cultures solve their problems and use these as frames of reference rather than Western definitions of mental health (Sue 1990).

Management

Management should —

- Ensure that the ethnic composition of a particular area is reflective of the consumer group.
- Have an equal employment policy.
- Ensure that workers have the freedom to work in a way that is appropriate to their own culture.
- Ensure that the criteria used in job selection are not always Pakeha defined, but take into account other factors which are culturally significant, for example age, experience and standing in the community.
- Research the ethnic composition of the population.

Conclusion

Culture is but one of the many factors which influence the way in which we see the world. Aotearoa-New Zealand is an increasingly multicultural society and, as mental health practitioners, we will be exposed to many different cultures in the course of our professional lives, thereby increasing the likelihood of “culture clash”. We need to acknowledge the differences created by our different cultures but also be aware of how culture can be misused. Strategies can be developed which are intra-personal, inter-personal and institutional. A good starting point is developing our own awareness of what culture means to us individually and finding appropriate and effective ways to address issues that arise. The paradigm used to provide psychotherapy still reflects positivism and does not recognise the effects of culture. So should the question be “is the current system effective” rather than shall we culture match? (Flaskerud 1990). Knowledge about different cultures is not enough; we also need a sensitivity to others and an awareness of our own racism and ethnocentrism.

Bibliography

- Belkin, G. S. (1988). Introduction to counselling. Iowa, Wm. C. Brown.
- Charonko, C. V. (1992). "Cultural influences in "noncompliant" behavior and decision making." Holistic Nurs Pract **6**(3): 73-78.
- D'Ardenne, P., & Mahtani, A., (1989). Transcultural counselling in action. London, Sage.
- Durvasula, R. S. and G. A. Mylvaganam (1994). "Mental health of Asian Indians: Relevant issues and community implications." Journal of Community Psychology **22**(2): 97-108.
- Ferguson, B., & Browne., E., Ed. (1991). Health care and immigrants, a guide for health professionals. New South Wales, MacLennan & Petty.
- Flaskerud, J. H. (1984). "A Comparison of Perceptions of Problematic Behavior by Six Minority Groups and Mental Health Professionals." Nursing Research **33**(4): 190-192.
- Flaskerud, J. H. (1990). "Matching Client and Therapist, Ethnicity, Language, and Gender - A Review of Research." Issues in Mental Health **11**: 321-336.
- Gauntlett, N., Ford, R., Johnson, N., & Navarro, T., (1995). "Meeting mental health needs of ethnic minority groups." Nursing Times **91**(42): 36-37.
- Gottheil, E. M., A. Thomas and Druley, Keith A (1981). "Matching Patient Needs and Treatment Methods in Alcoholism and Drug Abuse." Matching Patient Needs and Treatment Methods in Alcoholism and Drug Abuse. Charles C. Thomas Springfield, USA.
- Gruen, D. (1990). "Postpartum depression: a debilitating yet often unassessed problem." Health and Social Work **15**: 261-270.
- Henderson, G., & Primeaux, M., Ed. (1981). Transcultural health care. Menlo park, Addison Wesley.
- Howard, R. (1993). "Transcultural issues in puerperal mental illness." International Review of Psychiatry **5**: 253-260.
- Kareem, J. and R. Littlewood (1992). Intercultural therapy, themes, interpretation and practise. Oxford, Blackwell.
- Kumar, R. (1994). "Postnatal mental illness: a transcultural perspective." Soc Psychiatry Psychiatr Epidemiol **29**: 250-264.
- MacKinnon, L. (1993). "Systems in settings: The therapist as power broker." Australia New Zealand Journal of Family therapy **14**(3): 117-122.
- McAvoy, B. R., & Donaldson, L.J, Ed. (1990). Health care for asians. Oxford, Oxford university.
- McAvoy, B. R., & Donaldson, L.J, (1990). Health care for Asians. Oxford, Oxford university.
- Sawyer, L., Regev, H., Proctor, S., Nelson, M., Messias, D., Barnes, D. & Meleis, A.I. (1995). "Matching versus cultural competence in research: Methodological considerations." Research in nursing and health **18**: 557-567.
- Speight, S. L., Myers, L.J., Cox, C.I. & Highlen, (1991). "A redefinition of multicultural counseling." Journal of counseling & development **70**: 29-35.
- Stern, G., & Kruckman, L. (1983). "Multi-disciplinary perspective's on post-partum depression: An anthropological critique." Social Science Medicine(17): 1027-1041.
- Sue, D. W., & Sue, D. (1990). Counselling the culturally different. USA, John Wiley & Sons.
- Webster, M. L., Thompson, J.M.D, Mitchell, E.A, & Werry, J.S (1994). "Postnatal depression in a community cohort." Australia and New Zealand Journal of Psychiatry(28): 42-49.
- Wright, J. (1991). "Counselling at the cultural interface: is getting back to roots enough?" Journal of advanced nursing **16**: 92-100.