

Introduction

Globalization has meant that we live in a culturally rich and diverse world. Culture plays a very important role in influencing the way that people understand their psychological distress and seek help. Cultural factors influence how individuals and communities view the different interventions offered by health services. As we know, a number of culturally diverse communities find current practice of diagnosis and treatment in mental illness west-centric and not relevant to their cultural background. This can affect engagement of many individuals from minority cultural groups with services and can restrict the availability of treatment options. For this reason, practice in health services must also progress from the recognized Western traditions to incorporate the needs of culturally diverse populations.

In this chapter we introduce the concept of multiculturalism and globalization and start a dialogue about how culture influences epidemiology and outcomes in mental illness in multicultural societies. But before we do this, we define some commonly used terms that come up a lot in the following chapters as well. People use these terms which may seem straightforward in various ways like race, culture, and ethnicity. If you feel comfortable with your understanding of these, you might want to skip over them and move on but do come back if it emerges that your understanding is not quite as good as you thought or for clarification – we have had to do so at times whilst writing this book.

What Do the Terms Ethnicity, Race and Culture Mean?

A number of terms have been used, often interchangeably, when discussing culture in health and health care especially in relation to psychotherapy. These include ethnicity and race, culture, cultural sensitivity, cultural intelligence, cultural

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competence, and cultural adaptation. The following terms are used in different chapters of the book, and we define them here as we mean them to be understood with reference to their use elsewhere in the culture and ethnicity literature. There is undoubtedly sensitivity around discussion of these terms and individuals – academics and individuals from different cultural groups – often hold strong views about meaning and terminology. Some terms have become stigmatized and stigmatizing, used in very inappropriate ways with very negative connotations. Some terms are obviously wrong to use and others may be less so, especially to those who do not belong to the community concerned. We have tried to write in a way that avoids causing any offence to any reader but if any is incurred, it is not intended. We would be grateful if you were to let us know just as we strive with clients to ensure that the language we use with them is appropriate and non-stigmatizing.

Ethnicity and race

Defining ethnicity is complex. Fernando (1991) defines ethnicity as characterized by a sense of belonging, and determined by the identity of a group that shares common values and norms including language, religion, culture and racial background. A very similar conceptualization is provided by Tseng, Chang, and Nishijono (2005). Ethnicity, of course, is relevant to both minority groups and majority groups in societies. Each has its own group identity affected by its prevalence in specific societies – whether in the majority or not.

Discussion of issues associated with race presents a dilemma in its own right as historical associations make them very, and appropriately, sensitive. In the context of this book, race is used in two general ways. A geographical stance is that race refers to human population groups that have inhabited a certain geographical location long enough to develop distinctive genetic compositions (Fernando, 2010). However, race can also be considered as a social construct that is created within a set of legal, economic, and sociopolitical contexts (Blank, Dabady, Citro, National Research Council (U.S.), & Panel on Methods for Assessing Discrimination, 2004).

Culture

Mason and Sawyer (2002) and Helman (1990) define culture as a value system that is transmitted through various avenues including beliefs, art, religion, mythology, language, rituals and so forth. Therefore, culture is a set of guidelines (both explicit and implicit) that individuals inherit and learn as members of a particular society. It informs how they view the world, how they experience it emotionally and how they behave towards other people: in relation to supernatural forces or Gods, and to the natural environment. Cultural beliefs are important in psychopathology and presentation of illness – signs and symptoms – and in relation to health services. They influence all aspects of health care from help-seeking behaviours and pathways into care, to engagement, choice of interventions, and termination of treatments. Race

and ethnicity tend to be relatively fixed and enduring, whereas culture may be more flexible and dynamic, changing with circumstances.

Cultural sensitivity, intelligence, and competence

We refer to cultural sensitivity as the recognition of the diversity of viewpoints, attitudes, and lifestyles among different individuals. It includes the recognition that groups of people experience different types of stress in their living situations and utilize distinctive coping patterns (Tseng & Streltzer, 2006). Cultural sensitivity does not consider one's culture or the culture of the majority ethnic group as superior in any way. The attitude is one of cultural neutrality, appreciation and understanding.

Cultural intelligence is a multidimensional construct that refers to an individual's ability to work effectively in culturally diverse settings. It consists of four major components including cognitive, metacognitive, behavioural, and motivational cultural intelligence (Ang, Van Dyne, & Koh, 2006). Metacognitive intelligence stands for the processes through which individuals acquire knowledge and understanding of various cultures. The cognitive and behavioural components refer to the knowledge structure that one possesses about other cultures and the manifestations of culturally appropriate behaviours. Motivational cultural intelligence is the intensity and direction of the energy applied to thrive in multicultural situations. The conceptualizations of metacognitive, cognitive, and behavioural cultural intelligence closely resemble the awareness, knowledge, and skills factors in the model discussed earlier (Chao, Okazaki, & Hong, 2011).

Brown (2009) defined cultural competence as the capacity to be self-aware in regard to one's own identities and cultural norms, sensitive to the realities of human difference, and having possession of an epistemology, that is, a philosophy of knowledge and understanding of difference. We can then allow for creative responses to the ways in which the strengths and resiliencies inherent in identities inform, transform, and are also distorted by distress and dysfunction.

Cultural adaptation

Cultural adaptation is 'the systematic modification of an evidence-based treatment (EBT) or intervention (EBI) protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values' (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009). Cultural adaptation of an EBI would need to incorporate cultural competence, intelligence and cultural sensitivity as these would guide the adaptation process. Falicov (2009) described cultural adaptations to evidence-based interventions (EBIs) as procedures that maintain fidelity to the core elements of EBI while also adding certain cultural content to the intervention and/or its methods of engagement. We would also suggest that the success of such an adaptation should emulate, at least, the effectiveness of the original intervention.

Evidence-based practice

We have introduced the concept of evidence-based practice (EBP), so we need to describe it. The American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) defined EBP as ‘the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences.’ Empirically supported treatments (EST) and evidence-based treatments are terms used commonly in this context. However evidence derives not only from meta-analyses and randomized controlled trials (RCTs) but also from a range of methodologies including controlled and cohort studies, qualitative work, and, where little research is available, expert opinion. Evidence from a variety of sources is important in the area of culture and service delivery as RCTs may not always be possible to obtain. Even in the instances where RCTs have been done their relevance to long-term conditions with comorbidities or complex cultural and social situations may be limited. Thus, when we use the term ‘evidence-based practice,’ we believe that evidence has to weight the influence of different components and interpret the success of interventions. Client and carer choice are equally important influences, as are the practicalities of situations, for example, poverty and homelessness, that can impact on participation in interventions, and the availability of trained staff to provide them.

Globalization and Multiculturalism

Globalization can be understood as a phenomenon whereby an increased proportion of economic, educational, social, and cultural activity is carried out across international boundaries (Al-Rodhan, Nayef, & Stoudmann, 2006). Due to the factors associated with globalization, dispersal, and international integration of cultures and ethnic groups, multiculturalism has become an increasing phenomenon. Multiculturalism when understood as a descriptive term relates to cultural diversity (Heywood, 2000), and as a normative term it refers to ideologies or policies that promote this diversity. Thus multiculturalism is described as a society ‘at ease with the rich tapestry of human life and the desire amongst people to express their own identity in the manner they see fit’ (Bloor, 2010). The impact of multiculturalism can be conceptualized as operating at three levels (Lum, 2011):

1. At a macro level it impacts through policies that are determinants of health.
2. At a meso level it operates at a local level and in health care systems at institutional level.
3. At a micro level it impacts at an individual and provider level.

In developed countries big cities are cosmopolitan and cultural diversity or multiculturalism is now spreading into rural communities. The impact is greater in countries like the United States (US) and United Kingdom (UK) compared to

others like Japan. For example, the United States has always been a country of immigrants with an accelerated growth rate of ethnic minorities. Ethnic minorities has accounted for 92% of the growth in population in the past decade in the United States. It is expected that by 2040, the United States will become a country in which racial and ethnic minorities make up the majority of the population. In emerging economies, such as China and India, cultural diversity from recent immigration is just beginning, but existing cultural differences and internal movement have major effects on presentation and management of illness within services.

As global movement increases, awareness of the concept of multiculturalism and influence of culture, ethnicity, and race is increasing. We start with an overview of the prevailing cultural diversity in major parts of the world.

United States

The US census data view race and ethnicity as two distinct concepts. The latest US Department of Commerce (2012) highlights that Hispanic population constitutes 16%, while African Americans constitute 12.6% of the total population; Asian Americans make up 4.8% and mixed races 2.9% of the population. In the past 10 years the biracial category increased by 32%, indicating that the races are no longer distinct and there is increasing fluidity of racial identity in the United States (US Department of Commerce, 2012). In addition, an estimated 11.5 million undocumented immigrants were living in the United States as of 2011. Different ethnic groups can share many common features.

Hispanic persons share common features: they speak Spanish, (except for Brazilians who speak Portuguese), many are Roman Catholic, and they have common values and beliefs rooted in a history of conquest and colonization (McGoldrick, Giordano, & Garcia-Preto, 2005). The different sub-groups of Hispanic population are Mexican (63%), Puerto Rican (9%), Cuban (4%), Dominican (3%), and other groups (21%). The other groups are made up of a number of different groups each making up a very small percentage of the population, and hence they are all grouped together (US Department of Commerce, 2010). The Hispanic population increased by 15.2 million between 2000 and 2010, accounting for over half of the 27.3 million increases in the total population of the United States.

African Americans include individuals from Africa, South and Central America, the Caribbean, and elsewhere; and though many share the experience of enslavement, the communities have different historical and political experiences. The African American experience is often rooted in institutional mistrust based on a number of historical negative experiences as well as current racial discrimination. Help-seeking behaviours and perception of services are heavily influenced by these experiences. Personal beliefs of not being able to trust authority, experiences of a health care system that is shown to be less responsive to the needs of minorities and social adversity, as well as a dearth of African American health care providers (2% of psychiatrists and psychologists identify themselves as African American in

the United States) influence pathways into care that individuals take. Difficulty in trusting authority is magnified in therapy. For example, it is one thing to take a pill, as one has the ultimate control in throwing it away or putting it in the mouth. But laying bare emotions in front of someone who is representing authority is often much more difficult for someone who has suffered racial oppression.

The Asian American community is diverse with many groups; the main ones being Chinese (27%), Filipino (19%), Asian Indian (12%), Japanese (11%), Korean (11%), and Vietnamese (9%). Within the Asian American groups, there are 32 different primary languages spoken. While there are differences between the various Eastern cultures, they also share some common features, such as the centrality of the family unit and the collectivist and interdependence of the 'we' identity is stressed over the independence and autonomy of the 'I' identity. There is an ethos in the community to sacrifice one's happiness for the sake of a good life for one's kids (McGoldrick et al., 2005). Many Chinese Americans, Korean Americans, and Vietnamese Americans can have significant linguistic barriers that impact on their engagement with services.

Indian Americans tend to be among the most educated in the Asian American community, and are generally well off. Usually their immigration is for economic rather than political reasons, and they have the ability to return to visit the country of their origin. Asian Americans have the lowest utilization of mental health services, many tending to use the services when they are at crisis point. This is attributed to number of factors such as shame and stigma, lack of financial resources, differing conceptions of illness and health, and a lack of culturally competent services (McGoldrick et al., 2005).

Arab Americans are concentrated in pockets in Detroit, Los Angeles, New York/New Jersey, Chicago, and Washington, DC, area in the United States. They are generally well educated and economically successful, with 40% holding a bachelor's degree or higher and 73% working in managerial, professional, or administrative fields (Arab American Institute, CIC, 2003). Arab Americans are described as one of the most misunderstood and stigmatized ethnic groups in the United States (Erickson & Al-Tamimi, 2001). Arabs define themselves as including all people who speak Arabic language and are linked to the nomadic tribes of Arabia. Arabs are not uniform in their religious beliefs; and while majority are Muslims, about 10% are Christian. Two significant events in the past 20 years led to increase in the level of distrust between the Arab population and Western world in general and the United States in particular. These are the 1991 Gulf War and the attacks on the World Trade Center (9/11) and reactions to the event (Hays & Iwamasa, 2006). Since 9/11, negative stereotypes and prejudices against Muslims and Arabs have increased and according to the Federal Bureau of Investigation (FBI) reports, hate crimes against Muslims increased by 1,600% and against Arabs by 500% (Zogby, 2003).

Similar to many other Eastern cultures, one of the core features of Arab communities is the centrality of family. Arab families are patriarchal and organized hierarchically based on age and gender (Barakat, 1993). The father is at the top of the hierarchy and final authority rests with him. Extended family members

provide a great deal of support. Actions of one family member can reflect on the entire family. Members are expected to consider family first and themselves next (Abudabbeh, 1996). For a majority, arranged marriage is still the norm. Knowledge of the political history of the Arab population in developed countries can be helpful in discussion with clients, especially to overcome mistrust and build a therapeutic relationship.

Canada

In Canada, there has been a substantial increase in immigrant populations. In 2011, 25.9% Ontarians identified themselves as a member of the visible minority population, representing more than half of Canada's total visible minorities (6.3 million). British Columbia was the second highest. Between 2006 and 2011, Ontario's visible minority population increased nearly five times faster than the population as a whole (19.5% vs. 4.0%). Combined, the three largest visible minority groups in 2011 – South Asians, Chinese, and Blacks – accounted for nearly two-thirds (65.1%) of visible minorities (Statistics Canada, 2013). South Asians are the single largest visible minority group, accounting for 29.5% of visible minorities and 7.6% of Ontario's total population. Toronto has the largest population of Sri Lankans outside Sri Lanka. On this basis, responding to the diverse needs of Canadians is the third of seven basic principles of the mental health strategy (The Mental Health Commission of Canada, 2012).

Europe

In Europe, minority populations in the majority of countries are below 20%, although 11 countries have a higher proportion of people from ethnic minorities (Wolff, 2010). Largely, the immigrant minorities are of those countries of origin that were a former colony of the British, French, and Spanish empires. The reasons for immigration vary from post-colonial migration in cases of North Africans in France and South Asians in the United Kingdom; economic opportunity for example in Turkish, South, and South East European workers in Germany, Austria, and Switzerland and political persecution (Wolff, 2010) in many. In Europe, another source of cultural diversity is the repatriation of Germans, Russians, and Greeks from the Soviet Republic and Eastern Europe (Turton & Gonzalez, 1999). Belgium is rich in its multiculturalism due to waves of immigration of Polish, Italian, Turkish, and Moroccan immigrants among others between 1930 and 1980 (Mahieu, 1999). Norway has been considered an ethnically homogenous society with Saami being the major ethnic population. Other groups are Kven, Jews, Tater, and Roma (Engebriksen, 1999). Germany does not have a large indigenous minority population – there is a Danish-speaking minority, Frisian-speaking population, the Sorbians, the Sinti, and the Roma (Bosswick, 1999). Greece is a multicultural country especially due to the repatriation process from the Soviet Republic of Kazakhstan, Uzbekistan, and Georgia. A number of

Albanians have also migrated. They have a number of foreign refugees, for example Kurds from Iraq, Iran, and Turkey; Tamils from Sri Lanka; and asylum seekers from Poland, Lebanon, and Africa (Dikaïou, 1999).

Offering equal access to mental health services in a language in which diverse group of immigrants are fluent has been identified as a problem in a number of European countries and different strategies are being used like interpretation service on a needs basis in Ireland. Similarly challenges have been identified in providing equitable use of mental health services by ethnic and minority groups. Some countries have reported an underrepresentation of minorities in services (Belgium, Greece, and Switzerland in mental hospitals) and some over representation (the United Kingdom and Estonia in hospitals) (World Health Organization, 2008).

United Kingdom

The United Kingdom has approximately 9.1 million non-White population (Office of National Statistics [ONS], 2011), nearly 1 in 6 of the total population. Analysis of the 2011 census data has shown that the number of people in the United Kingdom from ethnic minority backgrounds went up by 2.5 million in 8 years from 2001 to 2009. A total of 1.75 million of the increase came about due to immigration, of which White foreigners rose by 550,000 from eastern European and migrants from Commonwealth countries. Asian Indian population rose to 1.43 million and Asian Pakistani population to 1 million. The rise in Black African population is due to the effect of migration from African Commonwealth countries notably Zimbabwe, Somalia, Eritrea, and Democratic Republic of Congo, seeking asylum. The fastest growing ethnic group in the United Kingdom is of Chinese people whose population nearly doubled to reach 452,000 in 2009. The mixed-race population has neared a million for the first time – from 672,000 in 2001 to 986,600 in 2009, an increase of nearly 50%. A third are mixed Afro-Caribbean and White, followed by Asian/White.

Statistics show that minority groups are concentrated in large urban centers and in 2011 approximately 40% lived in the London region (Black African, Black Caribbean, and Bangladeshi) (ONS, 2011). The second largest concentration is in West Midlands (13% of non-White population) followed by South East and North West (8%) (ONS, 2011). The biggest ethnic group in the United Kingdom is Asian Indians, and they have a substantially lower prevalence of mental disorder compared to Whites (Goodman, Patel, & Leon, 2009).

Australia

Australia ranked as the fourth largest immigrant receiving country in the past 150 years, after the United States, Canada, and Brazil, followed closely by Argentina. Until 50 years ago, they had the White Australia Policy which allowed them to keep non-Caucasians out. There have now been major changes to the make-up of Australia's population. Australia took in eastern and central Europeans as war refugees, then southern Europeans in the 1950s and 1960s and from the mid-1960s,

immigrants from the eastern Mediterranean were added to the population mix. With the abandonment of the White Australia policy in the early 1970s, Australia became a multicultural society comprising a culturally dominant Anglo (or Anglo-Irish) host society and a large number of ethnic minority groups. The development of ethnic enclaves which is commonly seen has resulted from economic disadvantage and social discrimination and provides cultural, social, economic, and, in some cases, physical security. The greatest de-segregation is apparent among those who arrived from Europe in the first decades after World War II, namely Germans, Dutch, other northwestern Europeans, and Italians and least among more recent immigrant streams from Asia, the Middle East, and the Balkans (Forrest, Poulsen, & Johnston, 2006).

Cultural Influence on Epidemiology and Outcomes of Mental Illness

Cultural differences are reported in the prevalence, clinical manifestation, diagnosis, treatment response, and outcomes for individuals with serious mental illness. Rates of schizophrenia have been found to be 2–14 times greater for African-Caribbean than for Whites in the United Kingdom (Fearon & Morgan, 2006; King et al., 2005). Similarly, Canter-Graae and Selten's (2005) meta-analysis of 18 studies demonstrated a significantly increased risk of schizophrenia in migrant groups from developing countries with significant variation of risk by both host countries and their countries of origin. Suggested risk factors are local environment, ethnic density, socio-economic status, or psychosocial adjustment in the host country. Brugha et al. (2004) conducted a survey among 10,000 people in the United Kingdom and found an increased risk of psychotic disorder in the group of African Caribbean's or Africans, and not in the groups of South Asians or 'others.'

A meta-analysis of the risk for psychotic disorders among first- and second-generation immigrants reported that there was no significant risk difference between generations, but there were significant differences according to ethno-racial status and host country suggesting that post-migration factors play a more important role than pre-migration factors or migration per se. The observed variability suggested that the risk is mediated by the social context (Bourque, Ven, & Malla, 2011).

Literature suggests that the Chinese have low rates of depressive illness, a strong tendency towards somatization and the presence of several unique culture-bound syndromes. They also have a relatively favourable prognosis of schizophrenia (Lin, 1983). The Chinese American Psychiatric Epidemiological (CAPE) study reported that Chinese Americans had moderate levels of depression as 7% of the sample reported depression in their lifetime (Sue, Sue, Sue, & Takeuchi, 1995; Takeuchi et al., 1998), which is lower compared with the national sample from the National Comorbidity Study (NCS) where 17% of the White American sample reported the same levels of depression (Kessler et al., 1994). Jenkins, Kleinman, and Good (1991) also noted that lifetime prevalence rates of unipolar depression,

based on DSM (American Psychiatric Association, 1987) criteria are higher in Western countries than Asian countries. The Epidemiologic Catchment Area (ECA) study showed no ethnic difference in the United States with bipolar disorder but reported lifetime prevalence rates of unipolar depression were higher for White Americans than for African Americans and Hispanics (Regier et al., 1993). Mexican immigrants have a significantly lower rate of major depression than US-born Mexican Americans (Burnam et al., 1987), and suicide rates have been documented as higher for Whites and Native Americans compared with African Americans and Hispanics.

Outcomes for people from minority groups using mental health services vary. It is postulated that clinician bias influences the rates of diagnosis and therefore has an influence on treatments prescribed. Compared to their White counterparts in Western countries, people from minority ethnic groups with schizophrenia are likely to be misunderstood and misdiagnosed and more likely to be treated with drugs and Electroconvulsive treatment (ECT) rather than psychotherapy (Fernando, 1998). African Americans are likely to use psychiatric emergency and acute care services, more likely to be diagnosed with schizophrenia, less likely to be voluntarily committed, and less likely to engage in long-term treatment (Adibimpe, 1994; Decoux Hampton, 2007; Worthington, 1992). Readmission rates are higher and minority patients are less likely to have their social and psychological needs addressed within the care planning process (Bhui, 2002). There is a higher rate of involuntary admissions and dissatisfaction with the services among this group (Bhugra, 1997; Bhui, 1998) with psychosis. These problems would appear to principally stem from communication problems in relation to mental health.

The US mental health system is complex, very fragmented and places undue linguistic, financial, and resource barriers for individual from ethnic minorities. A total of 16% of the overall US population is uninsured, compared with 25% of African Americans and 40% of Hispanic (U.S. Department of Health and Human Services, 2001). In a 2007 study, only 8% of Hispanics who did not speak English, who reported a need for mental health services, received services. Likewise, of the non-English speaking Asian/Pacific Islander population who reported a need for mental health services, only 11% received services (Hauenstein et al., 2007).

It is this level of disparity globally that demands a review of how services can be more receptive and responsive to the needs of people from cultural minority groups.

Conclusion

In a global world, psychiatry, wherever it is practised cannot be successful and complete without an awareness and understanding of cultural influences and differences in all aspects of mental health presentation. Diversity lends itself to learning from differences and integration of cultures which should be celebrated. The process of embracing diversity is a journey and fraught with possibilities and challenges which are elaborated in the next chapter.

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