*ABC of mental health*

# Mental health in a multiethnic society

Simon Dein

People from ethnic minorities comprise just over three million people or 5.5% of the British population. Their geographical distribution is highly uneven, with most living in greater London, the West Midlands, and other metropolitan counties.

Doctors in Britain increasingly encounter patients whose values and beliefs differ substantially from their own. Without a knowledge of other cultural beliefs and practices, doctors can easily fall prey to errors of diagnosis, resulting in inappropriate management and poor compliance. For example, a delusion is a false belief not amenable to reason and out of context with a person's cultural and religious beliefs: diagnosing someone as deluded must take into account cultural and religious factors.

Culture refers to the categories, plans, and rules that people use to interpret their world and act purposefully within it. These rules are learned in childhood while growing up in society. Cultural factors relate to mental illness in several ways. In the first instance, culture determines what is seen as normal and abnormal within a given society.

**Ethnic composition of Great Britain in 1991***

| Ethnic group† | Population (1000s) | Percentage of population: Of total (54 889 000) | Percentage of population: Of ethnic minority |
|---|---|---|---|
| White | 51 874 | 94.5 | |
| All ethnic minorities | 3 015 | 5.5 | 100 |
| Black: | 891 | 1.6 | 29.5 |
| Caribbean | 500 | 0.9 | 16.6 |
| African | 212 | 0.4 | 7.0 |
| Other | 178 | 0.3 | 5.9 |
| South Asian: | 1 480 | 2.6 | 49.1 |
| Indian | 840 | 1.5 | 27.9 |
| Pakistani | 477 | 0.8 | 15.8 |
| Bangladeshi | 163 | 0.3 | 5.4 |
| Chinese and others: | 645 | 1.1 | 21.4 |
| Chinese | 157 | 0.3 | 5.2 |
| Other Asian | 198 | 0.4 | 6.6 |
| Other non-Asian | 290 | 0.5 | 9.6 |

*Data from Commission for Racial Equality
†Categories according to Office for Population Censuses and Surveys

**"Culture is that complex whole which includes knowledge, beliefs, art, morals, law, customs, etc"**
***Definition of culture*, Tyler 1874**

**Culture relates to mental illness in several ways, especially its mode of presentation and response to treatment**

## Normal and abnormal behaviour

Definitions of what constitutes normal and abnormal behaviour vary widely from culture to culture and, within any given group, are dependent on demographic factors such as age and sex, social class, and occupation. Behaviours that may be perceived as abnormal at one time may be regarded as normal at other times, such as during carnivals. At these times it is culturally acceptable for men to dress as women or animals.

However, it seems that there is no culture in which men and women remain oblivious to erratic, disturbed, threatening, or bizarre behaviour in their midst. This is the more so when such behaviours occur without reason. In some cultures these behaviours may be seen as bad, meriting punishment, while in others they may be seen as signs of illness requiring treatment.

### Idioms of distress

British doctors may encounter behaviours that in other societies are acceptable, at least sometimes, but that could be interpreted as signs of mental illness: witchcraft and possession states are good examples of this. In many parts of the world these are culturally sanctioned ways of accounting for misfortune or expressing distress and are socially acceptable as such.

**"Obeah" is a form of witchcraft containing elements of Christianity, animism, folk medicine, and personal malevolence**

*Obeah*

A prevalent belief among immigrants from rural (and sometimes urban) communities of Africa and Asia is that it is possible to influence the health or wellbeing of another person by action at a distance. Culturally sanctioned ways of dealing with this often involve resorting to traditional healers or the use of counter-magic. Among Afro-Caribbean people in Britain a belief in obeah is common, and various countermeasures are employed.

A doctor presented with someone claiming to have been bewitched may misdiagnose a paranoid disorder and treat the patient with antipsychotic drugs. Involving a traditional healer would be more appropriate, and, in the absence of a suitable healer, a Christian priest might be acceptable since many believers in witchcraft also adhere to Christianity.

**Culturally appropriate reactions may be misdiagnosed as mental illness**

Miss E, a 20 year old woman who had emigrated to Britain from Trinidad, was compulsorily admitted to hospital after refusing food and drink for several days.

She believed that an obeah curse had been placed on her. A diagnosis was made of severe psychotic depression and treatment commenced under the emergency provisions of the Mental Health Act.

Response to treatment was poor, and a traditional healer was consulted, who lifted the curse. She began to eat and drink and showed no other signs of mental illness; she was discharged from hospital two days later.

*Possession*
This means the takeover of a person's mind and body by an external force such as a spirit or ancestor. The force controls the patient's thoughts and actions and deprives him or her of responsibility for these actions. In many parts of the world people freely admit to being possessed and to having spirits speak and act through them. Anthropologists point out that this mode of expression is deployed by disadvantaged members of a group to gain otherwise unattainable ends. The possessed person seems to be in a trance-like state and may perform actions that are totally out of character.

This state may be misdiagnosed as schizophrenia and treated as such. However, a more satisfactory outcome is likely if an exorcism is performed by the religious authorities, while the doctor should pay attention to the interpersonal problems in the patient's family that are likely to have been the precipitants.

West Indian Pentecostalist possessed by the Holy Spirit. While in this state the prophetess can speak in tongues. This may be mistaken for psychotic behaviour

## Explanations of mental illness

Each culture provides its members with ways of explaining mental illness, attempting to answer questions about why, and under what circumstances, someone becomes mentally ill. In the West emphasis is placed on psychological factors, life events, and the effects of stress, but in many parts of the Third World explanations of mental illness take into account wider social and religious factors. These include spirit possession, witchcraft, the breaking of religious taboos, divine retribution, and the capture of the soul by a spirit. Thus, these factors may need to considered if treatment is to be accepted. For example, taking tablets may not make sense to a patient who perceives his or her problems to lie in some religious misdemeanour.

**Patient and doctor may hold conflicting explanatory models of illness**

Mr C, a 30 year old Vietnamese patient, had suffered from schizophrenia for 10 years. He was extremely reluctant to accept depot antipsychotic drugs and suffered frequent relapses.

Discussions with him and his family, aided by an interpreter, revealed that they believed he was possessed by evil spirits. Since this was essentially a religious problem, they believed that drugs would be of no help.

This revelation did not immediately improve his compliance with treatment, but it provided a better understanding of his reluctance and increased his (and his family's) trust in his doctor

## Presentation of mental illness

Evidence from studies by transcultural psychiatrists and psychologists indicate that the major mental disorders, schizophrenia and depressive illness, occur worldwide.

*Schizophrenia*—Although the form of the disorder remains constant, culture determines the content of the illness and the way that it is expressed. Delusions and hallucinations draw on the symbols and images of the patient's cultural milieu. For example, in the West delusions often relate to technology (such as electricity being put into the brain, or being controlled by computer), while in Africa and India it is more common for delusions to have a religious basis (involving being taken over or harmed by gods or spirits).

*Depression*—Among people from the Far East and from lower socioeconomic groups in Western cultures, depressive illness may present primarily as physical symptoms (somatisation). Patients from such backgrounds might complain of lethargy and joint pains rather than low mood. Failure to recognise the underlying depression may result in patients being subjected to unnecessary physical investigations, prolonging the symptoms and reinforcing beliefs in their physical nature. Such symptoms are likely to respond to conventional antidepressant treatments.

**The prognosis of schizophrenia is better in Third World societies than in Western ones, and this may relate to support from families who share the patient's beliefs**

**Depression may present with somatic symptoms**

Mr K, a 52 year old married man from Delhi, had lived in Britain for over 20 years.

He presented to his general practitioner with a two month history of lethargy, weakness, and aching joints. He was subjected to several physical investigations, but no abnormality was detected.

When he was interviewed by a Hindi-speaking doctor he admitted to low mood, poor appetite, and anhedonia. A diagnosis of depressive disorder was made and he responded well to conventional antidepressant drugs

### Culture bound syndromes

These are culturally determined abnormal behaviour patterns that are specific to a particular culture or geographical region. The behaviours express core cultural themes and have a wide range of symbolic meanings—social, moral, and psychological. It is debatable how these disorders relate to conventional Western categories of mental illness. However, disorders recognised in the West such as anorexia nervosa, agoraphobia, and parasuicide may also be regarded as culture bound syndromes expressing notions of the role of women in Western society.

**Culture bound syndromes**

These are syndromes of behaviours or beliefs that are specific to certain cultures and reflect core cultural themes

*Amok*—A spree of sudden violent attacks on people, animals, or property affecting men in Malaysia
*Koro*—A belief that the penis is shrinking into the abdomen
*Evil Eye*—A belief among Latin Americans that illness is caused by the stare of a jealous person
*Susto*—A belief in the loss of the soul in Latin America
*Latah*—Syndrome of increased suggestibility and imitative behaviour found in South East Asia

**Migration and mental disorder**
Most studies of psychiatric disorder among immigrants to Britain are based on hospital admission records. West Indian immigrants have higher admission rates for schizophrenia than people born in Britain, although there has been concern that this may be accounted for in part by overdiagnosis of schizophrenia in this group. Similarly, the rate of schizophrenia in immigrants from West Africa aged 25-35 has been estimated at nearly 30 times that of the native British population. While about 8% of white patients in psychiatric hospitals are detained under the Mental Health Act, the figure for black patients is about 25%. Men from Northern Ireland are more likely to be admitted with a diagnosis of alcoholism than native British men.

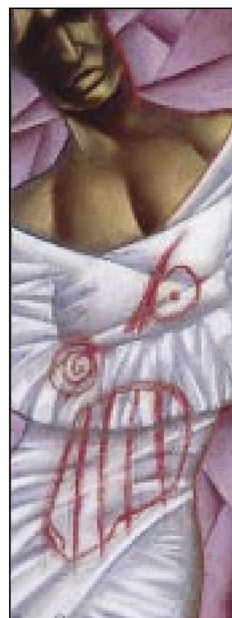
Of course, these statistics have major pitfalls and may not reflect the true prevalence of the disorders in these populations. Factors such as stigmatisation and racism are likely to account for some of the differences in admission rates.

Two theories have been proposed to account for the purported high prevalence of mental disorder among immigrants. The first is that people who are mentally ill are the ones most likely to emigrate; the second is that the stress of migration results in mental breakdown. There seems to be no single explanation for the differing rates of mental illness that is applicable to all minority or ethnic groups. Without doubt, factors such as dislocation from the native community, rejection by the host community, and difficulties in adapting to the cultural norms of the host society are perceived as intensely stressful and may contribute to mental breakdown in some vulnerable individuals.

**Hospital admission for schizophrenia by country of birth***

| | Men | Women |
|---|---|---|
| England | 9 | 9 |
| Ireland | 18 | 22 |
| Caribbean | 39 | 35 |
| India | 11 | 18 |
| Pakistan | 19 | 12 |

*Rates of hospital admission per 100 000 of each population over a period of 15 years (includes paranoid psychoses). Data from Cochrane R, Bal SS. Migration and schizophrenia: an examination of five hypotheses. *Social Psychiatry* 1987;22:181-91

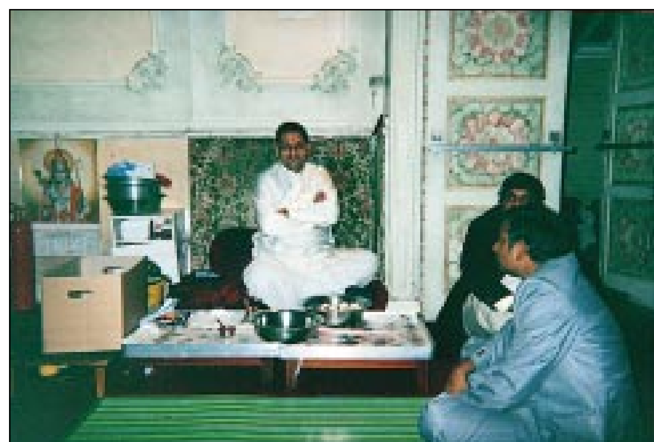


**Family structure**
Norms of family structure may differ from those in the West. Asian immigrants to Britain may have extended families, in which couples and their children may live under one roof with grandparents, aunts, uncles, and nieces. Concepts of respect and disrespect, loyalty, independence, position of elders, and obligations to the family and to the wider community all vary between different ethnic groups.

Conflicts arising between family members reflect this complexity. For example, the marriages of most Indian and Pakistani adults now resident in Britain were arranged for them by their parents. Often, one partner arrived from the home country just before the marriage ceremony while the other had been brought up in Britain. Such partners are likely to hold very different value systems, which, together with the obligation to honour their families' expectations, may place their marriage under considerable strain and lead to marital breakdown.

**Marital and family therapy for ethnic minorities must take into account cultural aspects of family structure or they risk creating their own problems. A family therapist's encouragement to a teenage daughter to strive for self fulfilment may be in direct conflict with the father's views of the authority of the male head of the family and his notion of good conduct**

**Psychosexual disorders**
The prevalence of psychosexual disorders among ethnic minorities in Britain is unknown, but it seems likely that most of these disorders are treated by indigenous healers. A common complaint by men from the Indian subcontinent is that sperm is leaking from the body into the urine. This complaint—called "jiryan" in Pakistan and "dhat" in India—may be prompted by anxiety over sexual potency or guilt about masturbation, and it may be compounded by cloudiness of the urine secondary to infection. It may also be used to explain various other problems due to organic disease or feelings of depression. It is important to recognise that this is not a delusion but a widely held belief.



Hindu religious healer: sick people visit the temple to commune with the gods

## Cultural aspects of treatment

The first step in treating patients from ethnic minority groups is, as with all patients, to decide if a problem exists and, if it does, to clarify its nature and degree. The general principles of this

process apply to all patients, but to these should be added a knowledge of the culture from which a patient derives. It is important to remember that, for many people from ethnic minorities, their everyday experience of racism is a major factor shaping their presentation and use of health services.

It is vital to find out how a patient seems to members of his or her own culture, and a doctor is likely to benefit from enlisting the help of the patient's family and close friends. Other useful, and often important, informants include religious officials and traditional healers, together with an interpreter when there are linguistic problems. It is, of course, important to be aware that an interpreter (especially if a member of the patient's family) may have a vested interest in presenting the patient as mad if the patient has broken a taboo, has been sexually promiscuous, or is resisting family pressures.

It may be decided that a mental health problem does not exist and that the "patient" is exhibiting culturally appropriate behaviour. In this case, a traditional healer may be more relevant than a general practitioner or psychiatrist. Traditional healers are better at treating certain problems than Western practitioners. For example, hakims (Moslem) and vaids (Hindu) may be better at dealing with psychosexual problems in their community than conventional psychosexual therapists.

When a mental disorder is recognised and it is appropriate to apply Western treatments such as drugs or electroconvulsive therapy, it is still important to elicit the patient's own explanatory model of the illness and attempt to explain the treatment in these terms. This will enhance the patient's trust in the doctor and improve compliance.

### Other factors affecting treatment

More work is needed on the different response to psychotropic drugs among different ethnic groups. It seems that south Asian patients show higher plasma concentrations of antidepressants than do white patients given a similar dose. These patients may be more sensitive to side effects and respond to lower doses.

Transcultural psychiatrists have found that management of mental illness in the Third World must take into account not only the patient but the wider kinship group of which the patient is a member. Treatment aims to resolve tensions among family members, which may have been causally related to the patient's illness. Psychiatric management of disorders among ethnic minorities in Britain must also take account of these factors.

### Intercultural therapy

Several centres have been established in Britain to provide psychotherapy to ethnic minority groups. Among the best known is the Nafsiyat Inter-Cultural Therapy Centre in north London. It is funded jointly by the local authority and the health service and offers formal psychotherapy to members of ethnic minority groups, taking account of racial and cultural components in mental disorder. It is involved in organising training courses and seminars in intercultural therapy and in conducting research into the efficacy of treatment.

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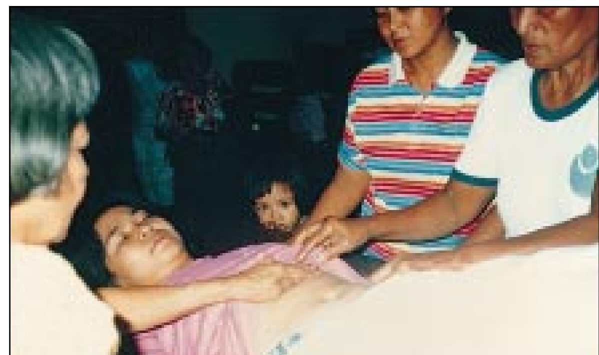
### Making mental health services more accessible for ethnic minorities

**Patients**
- To be treated with respect
- To be interviewed by staff with relevant language skills, or accompanied by an interpreter
- To be encouraged to explain their views, and to have the views of the doctor explained to them

**Doctors and other staff**
- To understand issues of racism and stigma in relation to the mental health of ethnic minority groups
- To be aware of, and be instructed in, the cultural norms and religious beliefs of the main ethnic groups consulting them
- To elicit and attempt to understand the explanatory models of illness used by their patients, and to consider the value of traditional healing methods

**Ethnic minority groups**
- To be provided with information about Western concepts of mental illness and its treatments
- To be consulted and involved in developing services
- To be encouraged to join patient support and advocacy groups



A Filipino psychic surgeon about to perform a psychic operation. This involves the supposed removal of tumours and tissues without the use of anaesthetic and leaving no scar

### Agencies providing mental health services for ethnic minorities

- African Caribbean Mental Health Association (tel 0171 737 3603) provides advice, counselling and psychotherapy for individuals, families, and groups
- Fanon Centre, Brixton, London (tel 0171 737 2888) is a drop-in and advice centre for mentally ill people of Afro-Caribbean origin. It has support groups for women, homeless people, and families
- Ipamo ("A place of healing," tel 0171 737 4585) is developing alternatives to hospital admission for black people with mental health problems
- Nafsiyat Inter-Cultural Therapy Centre, 278 Seven Sisters Road, London N4 (tel 0171 263 4130)
- Vietnamese Mental Health Project (tel 0171 326 5565) provides support for Vietnamese refugees and their families

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