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Article

At the crossroads of anthropology and epidemiology: Current research in cultural psychiatry in the UK

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Abstract

Cultural psychiatry research in the UK comprises a broad range of diverse methodologies, academic disciplines, and subject areas. Methodologies range from epidemiological to anthropological/ethnographic to health services research; mixed methods research is becoming increasingly popular, as are public health and health promotional topics. After briefly outlining the history of cultural psychiatry in the UK we will discuss contemporary research. Prominent themes include: the epidemiology of schizophrenia among Africans/Afro-Caribbeans, migration and mental health, racism and mental health, cultural identity, pathways to care, explanatory models of mental illness, cultural competence, and the subjective experiences of healthcare provision among specific ethnic groups such as Bangladeshis and Pakistanis. Another strand of research that is attracting increasing academic attention focuses upon the relationship between religion, spirituality, and mental health, in particular, the phenomenology of religious experience and its mental health ramifications, as well as recent work examining the complex links between theology and psychiatry. The paper ends by appraising the contributions of British cultural psychiatrists to the discipline of cultural psychiatry and suggesting promising areas for future research.

Keywords

anthropology, epidemiology, transcultural psychiatry, United Kingdom

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Introduction: History of cultural psychiatry in the UK

The past decade has seen heightened research into culture and mental health in the UK. Although the terms cultural psychiatry and transcultural psychiatry are sometimes used synonymously there, they have different meanings. The former refers to the study of culture and mental health generally whereas the latter refers to the psychiatry of ethnic minorities. Cultural psychiatry is slowly gaining a position of academic respectability in Britain. This is laudable given the fact that it is a multi-ethnic, multifaith, diverse society with ethnic minorities comprising 8% of the British population in the 2001 census.[1] Although not yet seen as a specific speciality within mainstream psychiatry, for example there is no faculty or section of cultural psychiatry within the Royal College of Psychiatrists, there are transcultural psychiatry, nursing, and psychology groups that are specializing in this area of applied work. On the whole, however, cultural psychiatry is still subsumed under the umbrella of social psychiatry.

This paper discusses cultural psychiatry research in the UK in the past decade and draws on a literature search of papers, books/chapters, websites, and grey literature. Because of the voluminous amount of research available we have focused on work in the past 10 years although where important we discuss earlier research which has impacted upon this work. We have selected studies which in our opinion have provided novel understandings in regarding the relation between culture and mental health or have had some impact on policy. Because of space constraints we have necessarily had to be selective. At least two edited text books on "cultural psychiatry" have appeared in the past 2 years—*Clinical Topics in Cultural Psychiatry* (Bhattacharya, Cross, & Bhugra, 2011) which presents an excellent overview of the impact of culture on symptom presentation, competency, and clinical management, and *Textbook of Cultural Psychiatry* (Bhugra & Bhui, 2010) which integrates both practical and theoretical knowledge and provides a framework for the provision of mental healthcare in a multicultural/multiracial society and global economy. More general books, often containing critical reviews of specific topics—-for example Sewell (2009) *Working With Ethnicity, Race and Culture in Mental Health*; Fernando and Keating (2009) (*Mental Health in a Multi-Ethnic Society*) and Fernando (2003, 2010b) *Cultural Diversity, Mental Health* and *Psychiatry and Mental Health, Race and Culture*—explore the complexity of what "culture" means in relation to mental health and the nuances in the meanings of "race." We have also consulted policy documents such as *EPIC, DRE, UK700, Count Me in Census* (Bhui, 2009; Bhui et al., 2012; Healthcare Commission, Mental Health Act Commission, & National Institute for Mental Health in England, 2007; McKenzie et al., 2001) and *Breaking the Cycles of Fear* (Sainsbury Centre for Mental Health, 2002) which have had some impact nationally and internationally, and reports of deaths of ethnic minority men in psychiatric institutions in the UK such as Broadmoor Hospital (*Report of the Committee of Inquiry Into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: "Big, Black and Dangerous?"*; Special Hospitals Service Authority, 1993).

There have been some recent overviews on the history of cultural psychiatry in the UK (e.g., Bains, 2005) and the current paper expands the discussion there. Early interest in the field was on Hungarian refugees (Mezey, 1960), Polish people who had settled in UK (Hitch & Rack, 1980), and Jewish people in East London (Fernando, 1975) alongside visible minorities, mostly immigrants or descendents of immigrants, rather on an anthropological notion of culture that would apply more widely to all people. Perhaps this was the legacy of a colonial history, or a consequence of visible power relations which were most strongly defined by ethnicity, race, and to some extent religious affiliation.

A number of individuals influenced the development of the field early on. Philip Rack, working in Bradford was the most prominent person in the field in the 1970s, predating people like Sashi Sashidharan and Roland Littlewood (both in Birmingham); Suman Fernando (Enfield); and Julian Leff (London). Rack's (1982) *Race, Culture and Mental Disorder* was a handbook offering the professional a guide to diagnosis and treatment across cultures and emphasized cultural variation in mental illness. The book was criticized for its depiction of culture as independent of political context and adopting a tacitly paternalistic approach. The new Transcultural Psychiatry Society was set up in 1975 and became a forum for psychiatrists and anthropologists interested in the subject of race and racism in psychiatry, and from its inception took on an antiracist posture (Burke, 1984). In 1984 the Transcultural Psychiatry Society modified its aims and objectives to promote equality of mental health irrespective of race, gender, or culture, and was committed to having a multiracial, multicultural, and multidisciplinary membership. Although the word "culture" was retained in the society's title, it was the impact of racism that was to "be recognised as the primary problem which the society [aimed] to correct" (Transcultural Psychiatry Society [UK], 1985, p. 73).

This form of cultural psychiatry, predominantly with a nonpsychiatric but nursing and social work membership, was committed to "revealing" the racism within psychiatry. It was asserted that by "culturising the problem of racism," psychiatry had preserved the racial status quo and power differential. There were several areas of particular concern. The society maintained that members of ethnic minorities were preferentially "psychiatrised," with excessive numbers inappropriately being given a diagnosis of schizophrenia in particular, and having received this diagnosis, a disproportionate number of patients were forcefully detained, medicated with antipsychotic drugs, and involuntarily admitted into secure hospitals under sections of the Mental Health Act. As Kirmayer and Minas (2000) note, "race" (in the social sense) and racism became a major focus of transcultural psychiatry in UK, leading to most epidemiological studies in UK using the concept of "ethnicity" (which includes "race") rather than "culture." Kirmayer and Minas (2000, p. 440) write:

> Countries like the United Kingdom and France, which were colonial powers, have experienced substantial immigration from former colonies. Such immigrants often have come with positive expectations arising from their experience of educational

and administrative systems that place the colonizing power in a favourable light, but they have encountered considerable racism and discrimination. In recognition of this problem, cultural psychiatry in England has focused on issues of inequalities in care for immigrants and on providing services that are explicitly anti-racist.

One influential publication in cultural psychiatry in those years was *Aliens and Alienists: Ethnic Minorities and Psychiatry* (Littlewood & Lipsedge, 1982) which focused on the psychological consequences of migration and prejudice for diverse cultural groups including West Indians, Turkish Cypriots, and Hasidic Jews. The authors combined the theoretical perspectives of psychiatry and social anthropology to examine the epidemiology of mental ill health among ethnic minorities and Black British, and concluded that mental illness was an intelligible response to disadvantage and prejudice. This text stimulated much debate both in the professional and lay communities, and, we would argue, has significantly stimulated research and clinical practice in transcultural psychiatry in the UK.

This critical attitude in British cultural psychiatry had a significant effect on practice in psychiatry and, particularly, areas of concern such as the purported high rates of diagnoses of schizophrenia in Black patients, higher rates of compulsory detention and possible misdiagnosis of immigrant and minority populations in the UK (e.g., Bebbington et al., 1994; Cole, Leavey, King, Johnson-Sabine, & Hoar, 1995; Dunn & Fahy, 1990; Littlewood, 1992). The importance of developing appropriate research tools, such as scales and questionnaires that were culturally valid was emphasized. Cultural psychiatrists also lobbied for more resources to be devoted to the mental health problems of ethnic minorities (Bains, 2005).

The developing field of transcultural psychiatry received significant criticism from sociologist Kobena Mercer (1986) who asserted that "culture" became reified as something special to Black people; furthermore he takes issue with the idea of racism as purely psychological, warning of the attempt to develop a psychotherapy which fails to incorporate questions of differential power relationships.

Kam Bhui and Swaran Singh (2004) note that research into culture and mental health has progressed a long way since the early focus on differential prevalence of schizophrenia across ethnic groups. A few studies evaluated different treatment experiences of various ethnic groups, the limited focus of much cross-cultural research and its methodological limitations was problematic, raising more questions than providing answers. The overall consensus was that ethnic minority patients experienced multiple adversities in their interactions with mental health systems, ranging from overt discrimination and racism to poorer provision of services. Early research paid little attention to service users' subjective experiences, and focused upon a narrow range of ethnic groups (African/Afro-Caribbean) and mental disorders (mainly schizophrenia), ignored differences within ethnic groups, and conceptualized culture in a narrow sense almost considering it as a synonym for race, and it focussed mainly on psychoses rather than common mental disorders.

In the past decade the dominant paradigms of previous research have been questioned and increasing numbers of studies have been designed which seek to answer additional questions in the relationship between culture and mental health. In part, such developments reflect a more in-depth understanding of culture and society, borrowing ideas from the disciplines of sociology, anthropology, cultural studies, political science, and postmodern critiques of mental health care (Bracken & Thomas, 2002). Furthermore, anthropological critiques of universal application of measurement scales and ethnographic approaches to examining culture and mental health have provided a recent focus for debate. For example, universalism and relativism were both contested as extreme and unhelpful ways of understanding the role of culture in mental health care (see Leff, 1990; Littlewood, 1990). Littlewood argued eloquently that more attention be given to local contexts, including indigenous systems of thinking, practice, and pathology, rather than trying to apply psychiatric concepts that carry assumptions about universalism and invariance across cultures.

Research in the past decade

Cultural psychiatry research in the UK comprises a broader range of topics. Methodologies range from epidemiological to anthropological/ethnographic, and to health services research, with mixed methods becoming increasingly popular. Anthropological approaches stress ethnography through participant observation while epidemiological approaches are quantitative. There have been longstanding tensions between the two disciplines based on their different epistemological premises. In recent years although epidemiology has been the predominant paradigm in public health research (including psychiatry), anthropological methods have been deployed often in the planning or formative phase of studies. Most commonly, applied epidemiological projects now generally include substudies based on use of "qualitative methods," usually in the developmental phase to be carried out by anthropologists (Béhague, Gonçalves, & Victora, 2008, p. 1702). These authors argue:

> A traditional form of collaboration between the two disciplines consists of using ethnographic insight to better develop questionnaires for quantitative surveys, primarily by improving the wording and social suitability of questions as dictated by formative ethnographic research exploring local taxonomies and illness categories.

However anthropological methodology has not always received recognition in its own right and often is seen as an "add on." Furthermore anthropologists themselves have commented that applied anthropology has more often than not been used in a superficial way, devoid of theory and reduced to an oversimplified methods "toolkit" (Bennett, 1995), and collaboration between the two disciplines has occurred in a parallel, rather than in a mutually beneficial way.

Although there is potential for tensions between the two methodologies, we would argue that mixed methods provide richer data than each methodology separately. Research on the cultural experience of depression among

white Britons in London is a good example of this mixed methods research (Jadhav, Weiss, & Littlewood, 2001). Other examples of research which attempts to tie together epidemiological and anthropological aspects are the Explanatory Model Interview Catalogue (EMIC) and the Short Explanatory Model Interview (SEMI) which bridge the gap between qualitative and quantitative methods of gathering health belief data (Lloyd et al., 1998; Weiss, 1997).

In this paper we cannot review health services research studies in detail, but more prominent themes include: the epidemiology of schizophrenia among Africans/ Afro-Caribbeans, migration and mental health, racism and mental health, cultural identity, pathways to care, and explanatory models, cultural competence and the subjective experience of mental health and illness, as well as population level research among specific ethnic groups such as Bangladeshis and Pakistanis.

Another strand of research which is attracting increasing academic attention is the relationship between religion, spirituality, and mental health; in particular, the phenomenology of religious experience and its mental health ramifications. In addition, recent work has examined the complex links between theology and psychiatry. Some of the underpinnings of UK thinking on this reflect the early findings of religious flavour in the presentations of Afro-Caribbean patients, as reported in *Aliens and Alienists*, and in more recent studies. Studies of spirituality and coping, and the relevance of prayer and worship have become important in health policy but are less researched or considered in everyday clinical practice.

Black psychosis, racism, and disadvantage in the UK

One particular focus of U.K. research has been the increased prevalence of psychosis among ethnic minority patients in the UK, particularly Africans and Afro-Caribbeans (e.g., Fearon et al., 2006; Fearon & Morgan, 2006). Members of the African Caribbean population have consistently been identified as far more likely (3–12 times more) to receive a diagnosis of schizophrenia than their White English counterparts. This phenomenon may be more extreme for those children born in the UK of first-generation migrants than for their parents.

Fearon et al. (2006) studied 568 individuals with psychosis presenting to secondary services in Nottingham, Bristol, and South East London. The results indicated remarkably high IRRs (incident rate ratios) for both schizophrenia and manic psychosis in both African-Caribbeans and Black Africans in both men and women. IRRs in other ethnic minority groups were modestly increased as were rates for depressive psychosis and other psychoses in all minority groups. These increased rates were found in all age groups in the study. The authors concluded that ethnic minority groups were at significantly increased risk for all psychotic illnesses but African-Caribbeans and Black Africans specifically appear to be at especially high risk for both schizophrenia and mania. They suggest that (a) either additional risk factors occur in African-Caribbeans and Black Africans or that these factors are particularly prevalent in these groups, and that (b) such factors increased risk for schizophrenia and mania in these groups. These studies also

demonstrated higher IRR in London compared with Nottingham or Bristol, providing more evidence of area effects, and environmental influences, along with the fact that the higher incidence in African Caribbeans was consistent in the second generation of immigrants. Biological lines of research have failed to fully explain these findings (Morgan, Charalambides, Hutchinson, & Murray, 2010).

In another study, Coid et al. (2008) explored the prevalence of psychosis in three boroughs of East London. Raised incidences of both nonaffective and affective psychoses were observed for all of the Black and minority ethnic subgroups compared with White British individuals. However, only Black Caribbean second-generation individuals were at significantly greater risk compared with their first-generation counterparts. No significant differences between first and second generations were found in other ethnic groups. Asian women, but not men, of both generations were at increased risk for psychosis compared with White British individuals. This was not the case for men. Patterns were broadly similar in relation to the affective psychoses.

Recent research has examined the roles of racism and disadvantage in mediating the higher prevalence of psychosis in Africans and Afro-Caribbeans. Cooper et al. (2008) investigated whether the higher incidence of psychosis in Black people is mediated by perceptions of disadvantage. Black ethnic groups had a four-fold higher incidence of first-onset psychosis which was significantly associated with a more deprived socioeconomic background and a greater perception of being disadvantaged. The authors concluded that this perception of disadvantage was not related to negative self-esteem or to the presence of psychotic symptoms, and queried whether it resulted from actual discriminatory experiences.

Veling et al. (2008) and Cantor-Graae and Selten (2005) argue that these effects can be found in all immigrant groups, and specifically related to discrimination or perceived discrimination—or something closely associated with perceived discrimination, in some ways closing the historical loop and reintroducing discrimination in the UK as a focus of further attention.

Although studies of the prevalence of schizophrenia have focused on people over 18 years old, one study suggests that Black children may have an increased prevalence of risk factors. Laurens et al. (2007) examined the associations of ethnicity and migrant status with a triad of putative antecedents of schizophrenia in a U.K. community sample of children aged 9–12. The study concluded that the prevalence of the putative antecedents of schizophrenia was greater among children of African-Caribbean origin residing in the UK than among White British children. This reflects the increased incidence of schizophrenia and elevated prevalence of psychotic symptoms among adults of African-Caribbean origin.

In relation to pathways to care, previous research has shown that there are more African Caribbean people in secure psychiatric facilities, and that African Caribbean patients are also more likely than White patients to be detained and compulsorily treated under the Mental Health Act. Oluwatayo and Gater (2004) found that poor engagement of African Caribbean patients with primary care and with mental health services appeared to be contributing to their high rates of compulsory admission.

Unlike previous studies, one study did not demonstrate difference in pathways into care between Afro-Caribbean and White patients in forensic settings. Bhugra Fahy, Nafees, and Mohan (2013) examined differences in pathways into mental health care in different forensic settings, and with two major ethnic groups. Seventy-four patients of African Caribbean ethnicity and 70 White patients were recruited to the study through psychiatric intensive care units, prison healthcare units, and medium secure units. All patients were asked about their pathways into care, their beliefs about their illness, their life history, and healthcare needs. Information was also collected to enable the two groups to be compared in terms of diagnoses and offending characteristics. The results confirmed that the African Caribbean patients were more likely to have a diagnosis of psychosis, especially schizophrenia, but the pathways into care for both groups were broadly similar, as were their beliefs about mental illness. There were few differences in unmet needs for healthcare between the two groups. The authors postulate that these recent findings may reflect changes in clinical practices and greater cultural and racial awareness by the service providers.

These findings of a higher prevalence of schizophrenia in U.K. ethnic minority groups reflect the exceptionally high incidence rate of schizophrenia and other psychoses in immigrant and ethnic minority groups in Western Europe generally (Singh & Burns, 2006) and have significant implications for service provision in areas with larger migrant communities. From an anthropological perspective we may question the limited versions of culture used by epidemiological psychiatrists who often "employ notions of culture that look like superficial national stereotypes than anything else" (Jenkins & Barrett, 2004, p. 4). Cultural psychiatrists need more nuanced and sophisticated notions of culture to explore how culture shapes symptom formation, in terms of constellation, form and content, the meaning of illness and its impact on outcomes. Furthermore we may also question the validity of taking schizophrenia as a cultural universal; some authors such as Fabrega (1989) have asserted that the disorder is predicated on a Western notion of self which may differ in non-Western cultures.

A number of authors stress the importance of institutional racism and the social construction of psychiatric categories in understanding these findings. Sashidharan (2001, p. 244) noted the importance of institutional racism in ethnic minority care "until we begin to address racism within psychiatry, in its knowledge base, its historical and cultural roots and within its practices and procedures, we are unlikely to achieve significant progress in improving services for minority ethnic groups." Jamaican psychiatrist Frederick Hickling (2005) pointed out how the Black incidence rate of schizophrenia was caused by social alienation and racism experienced by Black people in the UK, and to misdiagnosis by White British mental health professionals.

Fernando (2010a) accounts for the excess prevalence of psychosis in Black groups in terms of cultural misunderstanding coupled with institutional racism. For him, the excessive diagnosis of Black people as suffering from

schizophrenia/psychosis is very likely to result mainly from institutional racism inherent in society, represented in psychiatry within the diagnostic process. He notes (2010a: 198):

> Although the process of psychiatric diagnosis may appear robust, especially if the diagnostician uses a standardized procedure; yet, the diagnosis could be inappropriate because it fails to include issues of social and political context when (as happens in the diagnostic process) complex psychological, social, spiritual, political, and interpersonal issues are reduced to a single medical diagnosis located in people's minds.

This is of practical significance since what is put forward as "treatment" is actually a form of control. In a similar way Timini (2005) argues that institutionalized racism lies at the heart of the conceptual system used in psychiatry.

McKenzie in an article in the British newspaper *The Guardian* (2007) bemoans the fact that mental health services have exercised institutional racism over their treatment of Black patients. The government has asserted that this is not a useful term. The lack of a coherent prevention strategy is an institutional problem that requires institutions, not individuals, to act. He advocates for recognition of institutional racism as a way of overcoming racial disparities in treatment and outcomes. Although not discussed as widely in the US, Metzl (2009) points out the impact of institutional racism in Black American patients and traces the way that the diagnosis of schizophrenia is sensitive to sociopolitical influences.

Other common mental disorders and racism

Compared to psychosis, common mental disorders such as anxiety and depression have received relatively less attention. The EMPIRIC study (Weich et al., 2004) compared the prevalence of CMD (common mental disorders) among a representative sample of White English, Irish, Black Caribbean, Bangladeshi, Indian, and Pakistani individuals living in England using a standardized clinical interview. Middle-aged Irish and Pakistani men, and older Indian and Pakistani women, demonstrated significantly higher rates of CMD than their White English counterparts. The very low prevalence of CMD among Bangladeshi women was surprising given the high levels of socioeconomic deprivation among this group. The authors suggest that further study is needed to determine reasons for this variation.

Racism may contribute to this higher risk of CMD in ethnic minority groups. Karlsen, Nazroo, McKenzie, Bhui, and Weich (2005) explored the relationship between risk of psychosis, common mental disorder (CMD), and indicators of racism among ethnic minority groups in England and how this relationship may differ in particular ethnic groups. Experience of interpersonal racism and perceiving racism in the wider society each were found to have independent effects on the increased risk of CMD and psychosis, after controlling for the effects of gender, age, and socioeconomic status. The findings varied when they were conducted for separate ethnic and gender groups.

Further research is required to elucidate the role of gender, cultural, and ethnic factors in mediating the increased prevalence of CMD in ethnic minority groups in the UK and its relationship to racism. Studies of adolescents have shown lower rates of psychiatric disorders among Nigerian and Ghanaian boys, and Indian girls (Maynard & Harding, 2010a) and Bangladeshi young people (Stansfeld et al., 2004) as compared with White British youth. These findings are perhaps explained by different parenting styles including levels of care and control (Maynard & Harding, 2010b), or cultural identity (Bhui et al., 2005), but more work is needed to explain these findings.

Much of the work on CMD and ethnicity has focused on individuals under 65 years of age. Studies in the elderly and children are rare. Lawrence et al. (2006) explored how older adults with depression (treated and untreated) and the general older population conceptualize depression. A multicultural approach was used that included the perspectives of Black Caribbean, South Asian, and White British older adults. Depression was often seen as an illness arising from adverse personal and social circumstances that occur in old age. White British and Black Caribbean participants described depression in terms of low mood and hopelessness; South Asian and Black Caribbean participants frequently defined depression in terms of worry. Those prescribed antidepressants were more likely to acknowledge psychological symptoms of depression. Attribution varied between the ethnic groups. The authors concluded that a social model of depression is more appropriate to the beliefs of older people than the traditional medical model. These data have implications for managing ethnic minority groups in clinical care.

Another significant focus of research has been on ethnicity and self-harm. Cooper et al. (2012) as part of the Manchester Self-Harm Project examined the risk factors for repeated self-harm in South Asian and Black people in comparison to Whites. Risk factors for repetition were similar across all three groups, but excess was seen only in Black people presenting with mental health symptoms and South Asian people reporting alcohol use and not having a partner. The authors underscore the fact that clinical assessment in these ethnic groups requires recognition and treatment of mental illness and alcohol misuse.

Finally, it is important to point out that many members of ethnic minority communities experience a variety of disadvantages when they access, statutory mental health services under the National Health Service. Efforts have been made to resolve these issues by developing projects both within statutory mental health services and in the nongovernmental ("voluntary") sector. Fernando (2005) has provided a useful overview of the voluntary sector services in the UK although to date there is little work examining their effectiveness. Since the early 1980s many counselling and psychotherapy services have come on the scene in what is generally called the "Black voluntary sector." Some examples include Nafsyat in London set up in 1983 to provide psychotherapy for Black and ethnic minority (BME) patients (Kareem & Littlewood, 2000), the Qualb Centre in London providing counselling and complementary therapies for

Asian people (Gorman, 1995), and the Nile Centre in London, offering crisis support for Afro-Caribbean and African people with mental health problems.

Migration and mental health

Although migration has been typically associated with worsening mental health status among immigrants, compared to individuals in the host culture, individuals respond in diverse ways to the process of migration. Bhugra (2005) observed that migration can be a very stressful phenomenon. But not all migrants go through the same process. He sees migration as a series of events, which are influenced by a number of factors over time and these phases in return are influenced by other factors at social and individual levels. The available data concerning migrants' health in the UK, particularly at a large-scale quantitative level, is limited, including data that differentiates between economically advantaged and disadvantaged migrants, and how their social and economic status before migration compares to their social status postmigration.

Local studies in the UK and systematic reviews of studies in other European countries demonstrate higher rates of depression and anxiety among asylum seekers and refugees compared to the national population or other migrant categories (Raphaely & O'Moore, 2010). McColl and Johnson (2006) examined the characteristics of asylum seekers attending London Community Mental Health Team (CMHT). A total of 104 (11%) of the CMHT population were asylum seekers or refugees. Comorbidity was frequent with psychiatrists reporting significant diagnostic uncertainty for 30%. The most common diagnoses were depression (50%) and posttraumatic stress disorder (PTSD; 41%), and just over half had a psychotic diagnosis (53%). Social isolation was prevalent, levels of unmet needs were high and the group accessed few services other than CMHTs.

Recent work has moved beyond the typical preoccupation with migration and prevalence of mental illness to examine sex trafficking, the psychological ramifications of torture, and the experience of asylum seekers in the UK, particularly the mental health effects of prolonged stays at detention centres. Particularly vulnerable groups are children, and women who have suffered sexual and physical abuse (Lorek et al., 2009).

A quantitative survey of women internally or internationally trafficked for sex work or domestic service in selected European countries, including the UK, indicated that 70% of women had experienced both physical and sexual abuse during trafficking and that the majority suffered from severe physical and psychiatric symptoms such as back and abdominal pain, headaches, dizziness, gynaecological infections, depression, and anxiety (Zimmerman et al., 2008).

Bradley and Tawfiq (2006) studied the experience of torture among Kurdish immigrants in the UK. A total of 97 Kurdish asylum seekers requiring medical assessment for evidence of torture were examined and interviewed in the presence of an interpreter. Physical injuries, pain, disability, and psychopathology were

recorded for each. A wide variety of injuries and psychological disorders were described. Posttraumatic stress disorder (14%), major depression (7%), and organic brain damage (6%) were present in those surveyed. Methods of torture, previously unknown, were recorded for the first time. The authors highlight the long-term healthcare needs of this population, which are complex and require a multidisciplinary approach.

Palmer and Ward (2007) report on data derived from semistructured interviews of 21 refugees and asylum seekers that describe the problems experienced by those living in exile, and the need for a more integrated and holistic approach in the planning and delivery of services to support mental health. They assert that incorporating a perspective from service users will encourage providers to pay attention to the multitude of practical, social, cultural, economic, and legal difficulties that can impact the long-term mental health of this population. The implications highlight a need to shift from a simple biomedical model of the causes and effects of ill-health to a biopsychosocial model, which will require reorganization not only in healthcare but also in welfare, housing, employment, and immigration policy.

In relation to "detention centre psychiatry," Cohen (2008) explored the incidence of suicide and self-harm in asylum seekers in the UK, both those in detention and in the community. The investigation revealed that data recording was seriously erroneous or sometimes nonexistent. However, the data that existed from Immigration Removal Centres, coroners' records, and prison ombudsman's reports demonstrated high levels of self-harm and suicide for detained asylum seekers, as compared with the United Kingdom prison population. It was suggested that this could be accounted for routine failure to observe and mitigate risk factors. The author makes the following recommendations: coroners should document asylum seeker status and ethnicity of deceased, self-harm monitoring in the community should document asylum seeker status and ethnicity, health care in immigration removal centres should attain the same standards as U.K. prisons as a minimum, allegation of torture by immigration detainees should set off a case management review and risk assessment for continuation of detention, and this process should be subject to audit, and interpreters should be employed for mental state examinations unless subjects' English has been shown to be fluent. We would additionally argue that there is a need to address the conditions under which asylum seekers are detained and to provide support for the anxiety associated with the possibility of forced repatriation.

Cultural identity and mental health

Cultural identity refers to the identity of a group or culture, and the feeling of being included in this group or culture. Theoreticians such as Stuart Hall and Paul Du Gay (1996) believe identity to be affected by history and culture; rather than a finished product, they see it as ongoing production. Far from being static, cultural identities are modified through social processes of migration and globalization. Homi Bhabha (2004) discusses hybridization—the emergence of new cultural

forms from multiculturalism. He asserts that cultural identities cannot be reduced to pregiven, scripted, ahistorical cultural traits that define ethnicity. For him "colonizer" and "colonized" be viewed as separate entities that define themselves independently of each other. Developments of cultural identity vary in different cultural groups. Stephen Palmer and Pittu Laungani (1999) point out that whereas in individualistic cultures in the West identity is achieved, in collectivistic cultures such as India, identity is ascribed. To date, psychiatric research on cultural identity has not taken account of the insights of these theorists, instead deploying a limited conceptualization of cultural identity.

Kent and Bhui (2003) remark that cultural identity is a marker of the dynamic and complex psychological processes of adaptation and brings together social, psychological, and environmental research in a way that is not commonly seen in mental health research. It is one aspect of an individual's total identity that changes over time following exposure to the dominant culture and has recently gained renewed interest among mental health researchers. One recent focus of attention has been on cultural identity and its relationship to acculturation and mental health, particularly for young people living in multiethnic urban areas. There is some evidence from the U.K. that traditionalism—adhering to traditional lifestyles—might be related to lower prevalence of mental illness (Nazroo, 1997). During adolescence, integrated friendships and clothing preferences may be proxy measures for cultural identity.

Bhui et al. (2005) investigated cultural identity as a risk factor for poor mental health among 2,623 adolescents in East London. As measures of cultural identity, integrated friendship choices overall and more specifically for boys and Bangladeshi pupils, were associated with lower levels of adolescent mental health problems. In a subsequent study, Bhui, Khatib, et al. (2008) further investigated the influence of different cultural identities (friendship choices and clothing preferences) on the risk of common mental disorders among Bangladeshi and White British pupils. Cultural identity, expressed by clothing preferences, influenced mental health; the effects differed by gender and ethnic group. Bangladeshi pupils who preferred clothes from their own cultural group (traditional classification) were less likely to have mental health problems than Bangladeshi girls showing an equal preference for clothing from their own and other cultures (integrated classification). In gender-specific analyses, this finding occured only in Bangladeshi girls, and did not exist in Bangladeshi boys or White British girls or boys.

Explanatory models of illness and the subjective experiences of healthcare in ethnic minority groups

Research on patients' explanatory models has significant implications for clinical practice and might impact upon treatment satisfaction and compliance. Whereas in Western cultures mental illness may be explained in biological/psychosocial terms, in non-Western cultures understandings often draw upon spiritual traditions.

Unlike in the US, religious/spiritual explanations of illness and social misfortune are rare among the majority population of the UK.

Two studies have examined explanatory models of mental illness in minority groups in the UK. McCabe and Priebe (2004) compared explanatory models among people with schizophrenia deriving from four cultural backgrounds (UK Whites and Bangladeshis, African Caribbeans and West Africans) and explored their relationship with clinical and psychological characteristics. When biological and supernatural causes of illness were compared, Whites mentioned biological causes more frequently than the three non-White groups, who mentioned supernatural causes more frequently. Bangladeshis, who cited supernatural causes more frequently, either asked for alternative forms of treatment such as religious activities or no treatment at all. In contrast, Whites, who cited biological and social causes more frequently, preferred medication and counselling. The explanatory model, independent of ethnicity, was associated with levels of satisfaction with treatment, suggesting that what people believed about their illness influenced their experience of using mental health services.

Dein, Alexander, and Napier (2008) examined understandings of misfortune among East London Bangladeshis, particularly with respect to the role of jinn spirits—supernatural creatures in Arab folklore and Islamic teachings that occupy a parallel world to that of mankind. Deploying ethnographic interviews among 40 members of this community, the authors found that appeal to jinn explanations was commonplace at times of acute stress and unexplained physical symptoms. Use of traditional healers was frequent. These explanations were contested by different groups in the community. While elderly Bangladeshis readily offered jinn explanations for psychological disturbances, this was not so among younger community members, who referred to the elders as superstitious. The close relationship between jinn and mental illness indicates the need for clinicians to take account of religious factors in this community to assess their needs for psychiatric treatment.

There has been some recent work examining the experiences of mental healthcare in different ethnic groups in the UK. A particular focus has been on the relationship between biomedical and traditional healing and the role of religion as a coping strategy. Dein (2010) examined how a group of 30 Bangladeshi service users attending voluntary sector day centres, and 30 carers, understood their mental illnesses, attitudes towards treatment, and the types of religious help that they sought. It deployed focus groups and narrative-based interviews in Sylheti, a dialect of Bengali. Many service users and carers held "Western" social and psychological explanations for their illnesses: life events, major trauma, physical abuse, worries, "stress," and more specific cultural stressors (e.g., loss of social honour (*izzat*), inability to send remittances home, and the impact of their illness on marriage prospects.

Stressors were frequently exacerbated by poverty and overcrowding. Spirit possession and witchcraft were frequent explanations for their illness. Many people had sought help from traditional healers but were sceptical of these healers at the

same time. Prayer, consulting imams, and reading the Qur'an were generally cited as helpful. Informants argued for the need to more closely integrate religious and psychiatric treatments.

Religion and mental health

Religion and its relationship to mental health has become a topic of increasing academic interest in the UK over the past decade. Although much of the North American research predominantly uses epidemiological methods to assess mental health in relation to a number of religious variables (attendance, belief, prayer, etc.) much of the work in the UK has focused upon the phenomenology of religious experience and its relationship to psychopathological states such as psychosis.

Dein and Littlewood (2007) explored the phenomenology of religious voices among Pentecostal Christians in London. Forty members of an English Pentecostal church were asked about communications from God, 25 of whom reported an answering voice from God; 15 of them hearing Him aloud. Unlike "psychotic" voices, God's voice was described as calm and supportive and its content was consistent with scriptural teachings. The voice of God could not be held to be ipso facto pathological and many reported psychological benefits while experiencing major life stressors. This research supports other findings suggesting that spiritual experiences can alleviate mental distress (e.g., Jackson & Fulford, 1997).

Another topic that has received attention is religious coping. To date there is a dearth of data concerning how ethic minority groups use religious coping in the context of distress. Bhui, King, Dein, and O'Connor (2008) undertook a large public health study of six ethnic groups in the UK in the EMPIRIC study. A qualitative component comprised 116 people. The sample included 49 men and 67 women of Black Caribbean, Black African, White British, Irish, Indian, Bangladeshi, and Pakistani origin. The sample included those between 25–50 years old. The majority of people were Muslim (40) or Christian (25) with smaller numbers of Sikh, Hindu, Buddhist, and Rastafarians. Formalized religion was not essential for individuals to make use of religious coping. African Caribbean and Bangladeshi participants most often stated that formalized religious practices were central to their coping when compared with Indian, Irish, Pakistani, and White British participants. Positive coping strategies included prayer, listening to religious radio, using amulets, talking to God, having a relationship with God, and trusting God. Cultural or spiritual coping practices were indistinguishable from religious coping among Muslims. There was a greater degree of choice and personal responsibility for change among Christians who demonstrated a less deferential and more discursive quality to their relationship with God. Informants reported that the use of religious coping commonly facilitated emotional change.

Finally, there has been increased interest in asking health professionals about religion/spiritual issues in mental health consultations. Dura Villa, Dein, Haggar,

and Leavey (2011) conducted a qualitative study exploring psychiatrists' attitudes to religion and spirituality within their practice, and attempted to examine how these are resolved in the therapeutic relationship with, and management of, religious patients. Twenty semistructured interviews were conducted with psychiatrists working in London. The study found a strong degree of dissonance amongst the migrant psychiatrists between their practice in their home countries—of incorporating patients' religious beliefs—and in the United Kingdom—of excluding them. The authors underscore a need for more detailed understanding of religious factors in mental healthcare.

Guidelines and cultural competency

Kirmayer (2012) notes that cultural competence is increasingly recognized as an essential skill set for all mental health professionals, especially those working in multicultural milieus or with ethnic minorities. The Royal College of Psychiatrists in the UK has attempted to improve the quality of care received by migrants and by ethnic and religions minorities. At a time of controversial and disquieting concerns about institutional racism in mental health care, the college undertook a review of all its procedures and policies (Hollins & Moodley, 2006; Moodley & Cameron, 2005) and has since provided a change in its training curriculum, guidelines for inpatient care, and guidelines for the care of migrants, in collaboration with the World Psychiatric Association (Bhugra et al., 2011). Rathod and Kingdon (2009) and Rathod, Kingdon, Phiri, and Gobbi (2010) have also adapted cognitive behavioural therapy (CBT) therapies for people of diverse cultural backgrounds.

   More recent work on cultural competency, at individual and organizational levels (Adamson, Warfa, & Bhui, 2011; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007), also shows a promising trend, in that cultural competency training is recognized as something that is essential although it is still resisted on many fronts (see Adamson et al., 2011).

   Despite this increasing attention given to the role of culture in psychiatric training and healthcare, the UK lags far behind other countries such as Canada which have developed more sophisticated models of cultural competence. Kirmayer (2012) has critically appraised the concept of cultural competence and argues that the cultural competence literature tends to treat culture as a matter of group membership and assumes that members of a group share certain cultural "traits". Culture is reified and essentialized as consisting of more or less fixed sets of characteristics that can be described independently of the individual's life history and current social context. Kirmayer asserts that this is an outdated view, now largely abandoned by anthropology, which see cultures as hybrid, mixed, and undergoing flux and change where the individual interacts with multiple communities. He argues for an approach to cultural competence based on this more contemporary view of culture. He proposes that mental health professionals consider alternatives to cultural competence in addressing diversity such as

cultural safety or cultural humility which focus on issues of power in an effort to move the clinical encounter towards greater dialogue and accountability, which "must consider how to meld recognition of, and respect for, the identity of individuals and communities with attention to the dynamic, contested, and often highly politicized nature of individuals' interactions with collectivities, both local and global" (p. 155).

Conclusion

We have outlined above some of the areas of research in cultural psychiatry which appear promising. Future work should examine the factors mediating the reported increase in prevalence of mental illness in ethnic minority groups, particularly the impact of racism, discrimination, and cultural identity and their therapeutic implications. There is a need to explore the subjective experiences of mental illness in diverse cultural groups, their explanatory models, their use of indigenous forms of healing, and their implications for mainstream service provision. One focus should be on collaboration between traditional healing and psychiatric services. Emphasis should be given to looking at ways for improving cultural competence in working with diverse groups.

There is emerging evidence that religion and spirituality are important coping strategies for those with mental illness and have implications for prevention and treatment. Future work needs to focus on what specific aspects of religious practice are beneficial and how these can be harnessed for clinical benefit. For instance, how can religious/spiritual ideas be incorporated into psychotherapy and what is the role of clergy in mental healthcare?

There has been recent interest in the concepts of recovery and resilience among "survivors," service users in the UK. Research in this area is at an early stage but one report provides a useful model for conducting future research in this area. *Recovery and Resilience: African, African-Caribbean and South Asian Women's Narratives of Recovering From Mental Distress* is the report of a research project conducted by the Mental Health Foundation exploring the concept and settings of recovery from mental and emotional distress. The project collected positive stories of recovery and resilience and highlight what helped women from these communities in their healing process (Khalatil et al., 2011).

Finally, work on deprivation and power inequalities deriving from ethnic minority research is relevant towards an understanding of what mediators account for ethnic inequalities, and whether these mediators are also responsible for problems found in other ethnic groups and the majority population, for whom services are supposed to be designed. Thus discrimination, stigma, poverty, the power differential in therapeutic relationships, a lack of optimism and the accommodation of personal narratives in a care plan, and a highly trained and competent workforce are all relevant to mental health services users in general, irrespective of ethnic minority status. In this way cultural psychiatry research can benefit theory and practice in mainstream psychiatry, and also mainstream health care, beyond psychiatric practice.

Note

1. The total minority population in 2001 was 4.6 million (or 7.9%). The largest category was South Asian people, consisting of 2 million people or 3.5% of the population, half of whom were Indian. There were 1.15 million Black people, with more than half a million Black-Caribbean people. The Black African population has expanded very rapidly and is almost as large as the Black-Caribbean population, which is much older. Many of the children of Black-Caribbean parents are included to the mixed parentage ethnic groups, which contain 677,000 people, almost as many as the number of people from Chinese and other ethnic groups (Owen, 2001).

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