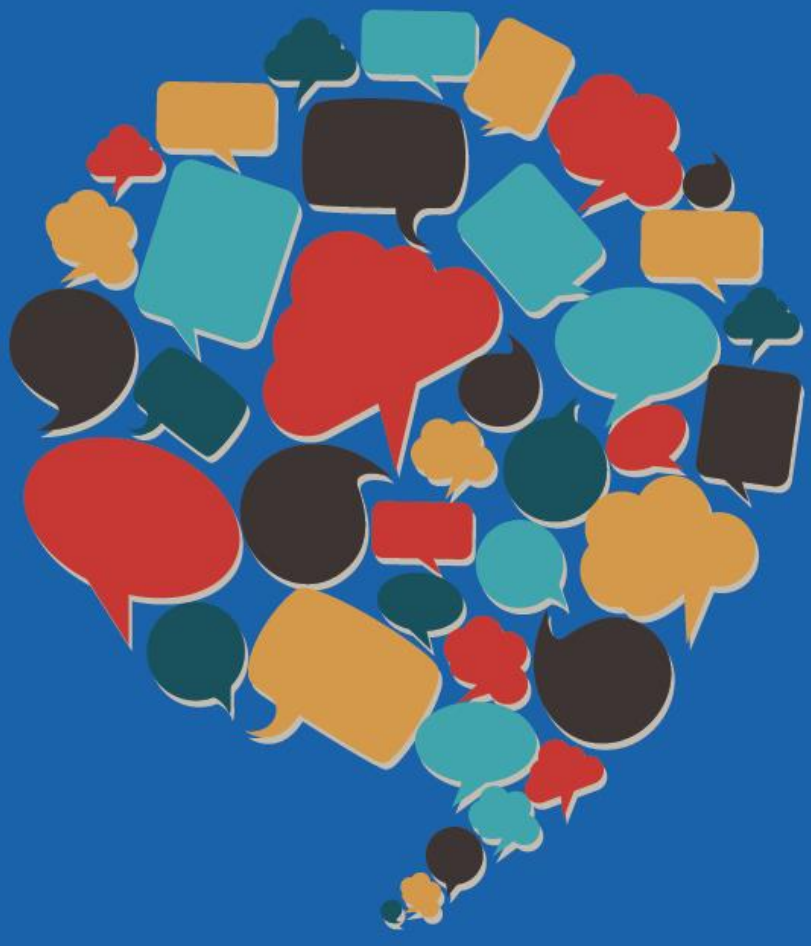
OPEN MINDS II

Promoting Mental Health and Well-Being in the Community



Intercultural Approaches on Mental Health

The cultural determination of behavior

With most health conditions it could be expected that, regardless of what country or culture the person affected was living in, the experience of illness would be very similar and that there would be common agreement, for instance, about who was experiencing measles and who was suffering from asthma.

But what if an individual said they could hear the voices of their dead ancestors or reported that they had been temporarily abducted by aliens? Would they be considered 'mad' or believed? The answer to that question might depend on whether they lived in Europe, Africa or America[1].

The assessment of mental health disorders primarily depends on assessing what the person concerned says and does, or on what other people report about an individual who is causing them concern.

There are at least two aspects of this process that can be problematic in relation to cultural differences:

- Firstly, the diagnostic manuals that are used tend to be developed within the North American and European traditions of psychiatry and are likely to be affected by the cultural norms that prevail in those parts of the world.
- Secondly, when the mental health practitioner and their patient come from different cultural backgrounds it may be difficult for the practitioner to know if what they are seeing is a symptom of a mental illness or simply a different way of thinking, feeling or behaving linked to the patient's background.

Cultural differences affect aspects of behavior significant for making a diagnosis:

- Behaving in a loud and extroverted fashion could be taken as a sign of mania.
- Similarly engaging in a prolonged period of mourning following a close bereavement could be interpreted as grief that has spilled over into clinical depression.

But both behaviors could be culturally determined. In the UK, admissions to psychiatric polyclinics of men from African and Caribbean origins are roughly twice as high as for white British men and there has been much concern that this group is being over-diagnosed with psychotic conditions[2].

Attitudes toward mental health issues vary among individuals, families, ethnicities, cultures, and countries. Cultural and religious teachings often influence beliefs about the origins and nature of mental illness, and shape attitudes towards the mentally ill. In addition to influencing whether mentally ill individuals experience social stigma, beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment. Therefore, understanding individual and cultural beliefs about mental illness is essential for the implementation of effective approaches to mental health care[3].

Intercultural dimensions of mental health issues

Each belief system provides a rational for psychosomatic symptoms and methods of treatment that logically relate to the same rational. Examined more closely, your chosen belief system will likely also interlock with its own distinctive cosmology and with a theoretical stance for the control of social behaviour[4].

Global health has been defined as an area for study, research, and practice that places a priority on achieving health and improving equity in health for all people worldwide; that emphasizes transnational issues, determinants, and solutions; that involves many disciplines (within and beyond the health sciences); and that promotes collaboration. Global mental health naturally follows the same path, except that the emphasis is placed upon mental health and behavioural problems, particularly those that significantly affect cost and disability worldwide.

Historically, the anthropological perspective in global mental health originally focused on the description of exotic syndromes from distant lands, advanced important theories concerning the “emic” (from phonemics, meaning local) and “etic” (from phonetics, meaning universal) perspectives on mental disorders. In today’s globalized world, however, with the massive waves of migration and giant communication networks, these syndromes have less clear boundaries, so they can be seen in many countries, even highly developed ones. The “etic” or universal approach has gained impetus with studies sponsored by the World Health Organization showing that major psychiatric disorders can be reliably identified in most countries and cultures and that psychiatric classifications such as DSM-5 and particularly ICD-10 appear to have universal acceptance and appeal. The fact that the “emic” perspective may be losing ground does not alter the obvious impact that cultural background has on the presentation, treatment preferences, and treatment response of mental disorders across the globe[5].Simply put, Manuals and Guidelines are useful provided they are viewed under (cultural) perspective and used with caution and cultural sensitivity.

Definition of Cultural Competence

Cultural competence is the ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention. Cultural competence recognizes the broad scope of the dimensions that influence an individual’s personal identity. Mental health professionals and service providers should be familiar with how these areas interact within, between and among individuals.

These dimensions include:

- **race**
- **ethnicity**
- **language**
- **sexual orientation**
- **gender**
- **age**

- **disability**
- **class/socioeconomic status**
- **education**
- **religious/spiritual orientation**

Cultural Barriers to Mental Health Care

Cultural barriers that prevent members of minority populations from receiving appropriate care include: mistrust and fear of treatment; alternative ideas about what constitutes illness and health; language barriers and ineffective communication; access barriers, such as inadequate insurance coverage; and a lack of diversity in the mental health workforce.

Cultural Biases and Stereotypes

In general, discrimination refers to the hostile or negative feelings of one group of people toward another. It can cause bias in service provision and can prevent people from seeking help. Cultural competency must address the biases and stereotypes that are associated with an individual's culture and various identities. Forms of discrimination include:

Racism: prejudice or discrimination based on a person's race, or on the belief that one race is superior to another;

Ageism: bias toward an individual or group based on age. For example, young people may be stereotyped as immature and irresponsible; older adults may be called slow, weak, dependent and senile;

Sexism: discrimination or prejudice based on gender;

Heterosexism: prejudice against people who are gay, lesbian, bisexual, transgender, or intersex. It is also the assumption that all people are heterosexual and that heterosexuality is correct and normal;

Homophobia: the fear and/or dislike of homosexual people or homosexuality;

Classism: any form of prejudice or oppression against people who are members of (or who are perceived as being similar to those who are members of) a lower social class;

Religious intolerance: an inability or unwillingness to tolerate another's beliefs or practices.

How to Incorporate Cultural Competency Standards into Practice

The notion of Respect and Acceptance of Human Diversity

Mental health professionals and service providers can improve their cultural competence by taking the following steps:

- Use open-ended questions to identify each person's unique cultural outlook.
- Re-evaluate intake and assessment documentation, as well as policies and procedures, to be more inclusive.

- Employ qualified mental health workers who have diverse backgrounds and are fluent in the languages of the groups being served.
- Understand the cultural biases of staff and provide training to address educational needs.
- Understand and address the cultural biases in program design.
- Identify resources, such as natural supports, within the community that will help an individual recover.
- Design and implement culturally sensitive treatment plans.
- Evaluate procedures and programs for cultural sensitivity and effectiveness.
- Survey beneficiaries and workers to elicit their understanding of cultural competence and culturally competent practice.

The mental health system is slowly improving, while extended problems and gaps in services still exist. When you are seeking and/or providing mental health services, it is good to understand that cultural differences influence every individual, both provider and beneficiary. With the proper training for mental health workers and educational materials for members of minority populations, culturally sensitive services can be effective in treating and possibly preventing episodes of acute mental illness.

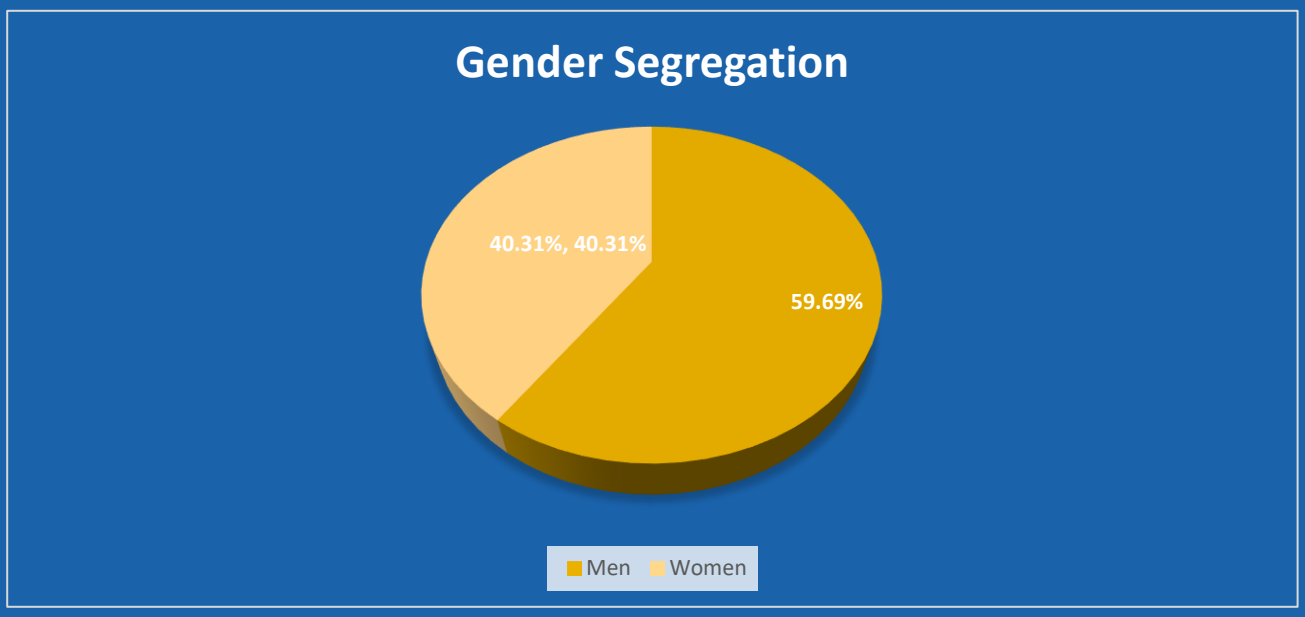
Stigma and cultural sensitivity

Although the reasons for stigmatization are not consistent across communities or cultures, perceived stigma by individuals living with mental illness is reported internationally. For instance, the World Mental Health Surveys showed that stigma was closely associated with anxiety and mood disorders among adults reporting significant disability. The survey data, which included responses from 16 countries in the Americas, Europe, the Middle East, Africa, Asia, and the South Pacific, showed that 22.1% of participants from developing countries and 11.7% of participants from developed countries experienced embarrassment and discrimination due to their mental illness. However, the authors note that these figures likely underestimate the extent of stigma associated with mental illness since they only evaluated data on anxiety and mood disorders[6].

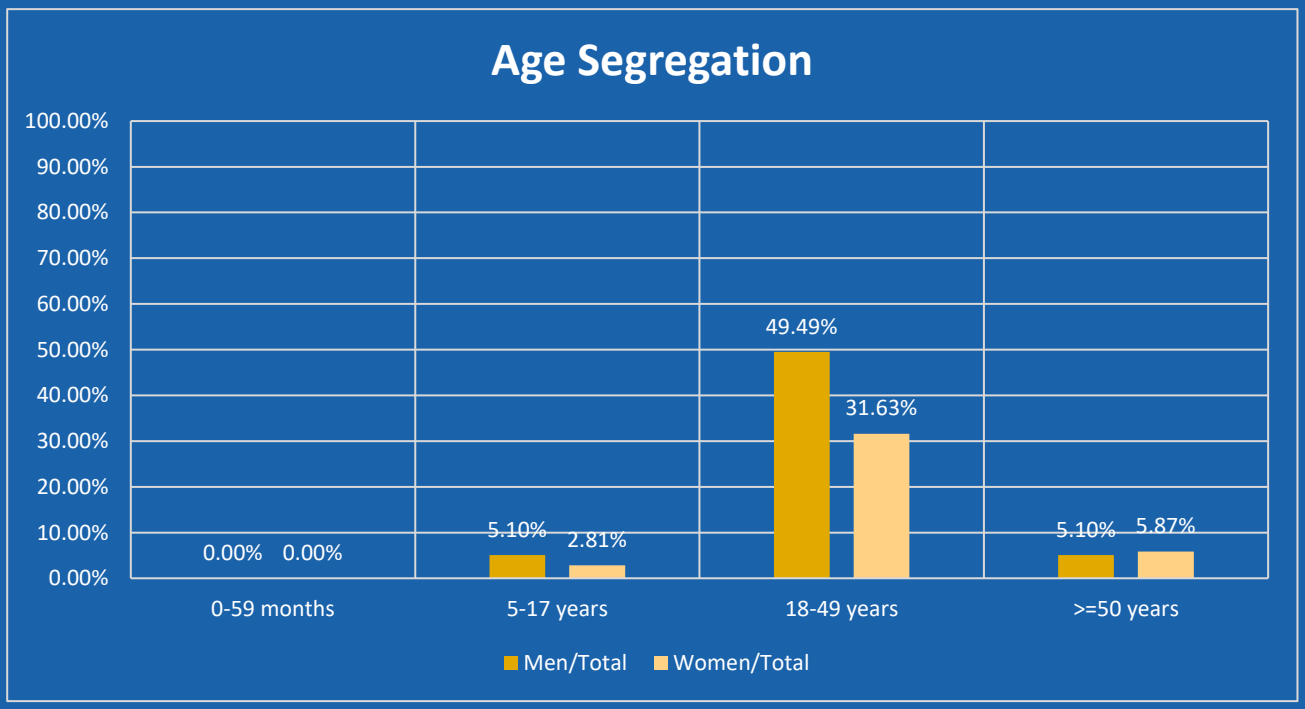
Presenting mental health care services in culturally sensitive ways is essential to increasing access to and usage of mental health care services, as local beliefs about mental health often differ from the Western biomedical perspective on mental illness.

Mental health professionals and service providers must be aware of how stereotypes and stigma influence not only their beneficiaries but also their own thoughts and views of others.

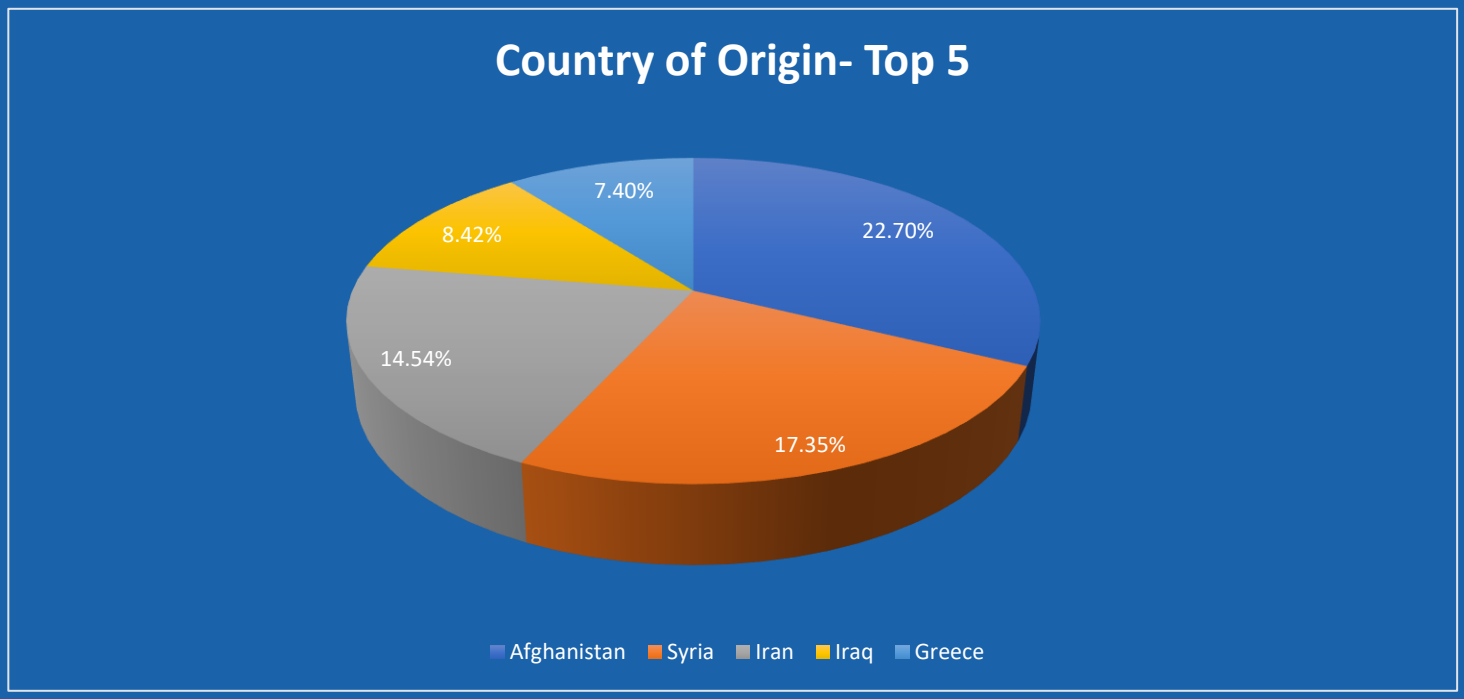
Demographic Data of "Open Minds II"project beneficiaries regarding age, gender, country of origin for the period January – June 2019



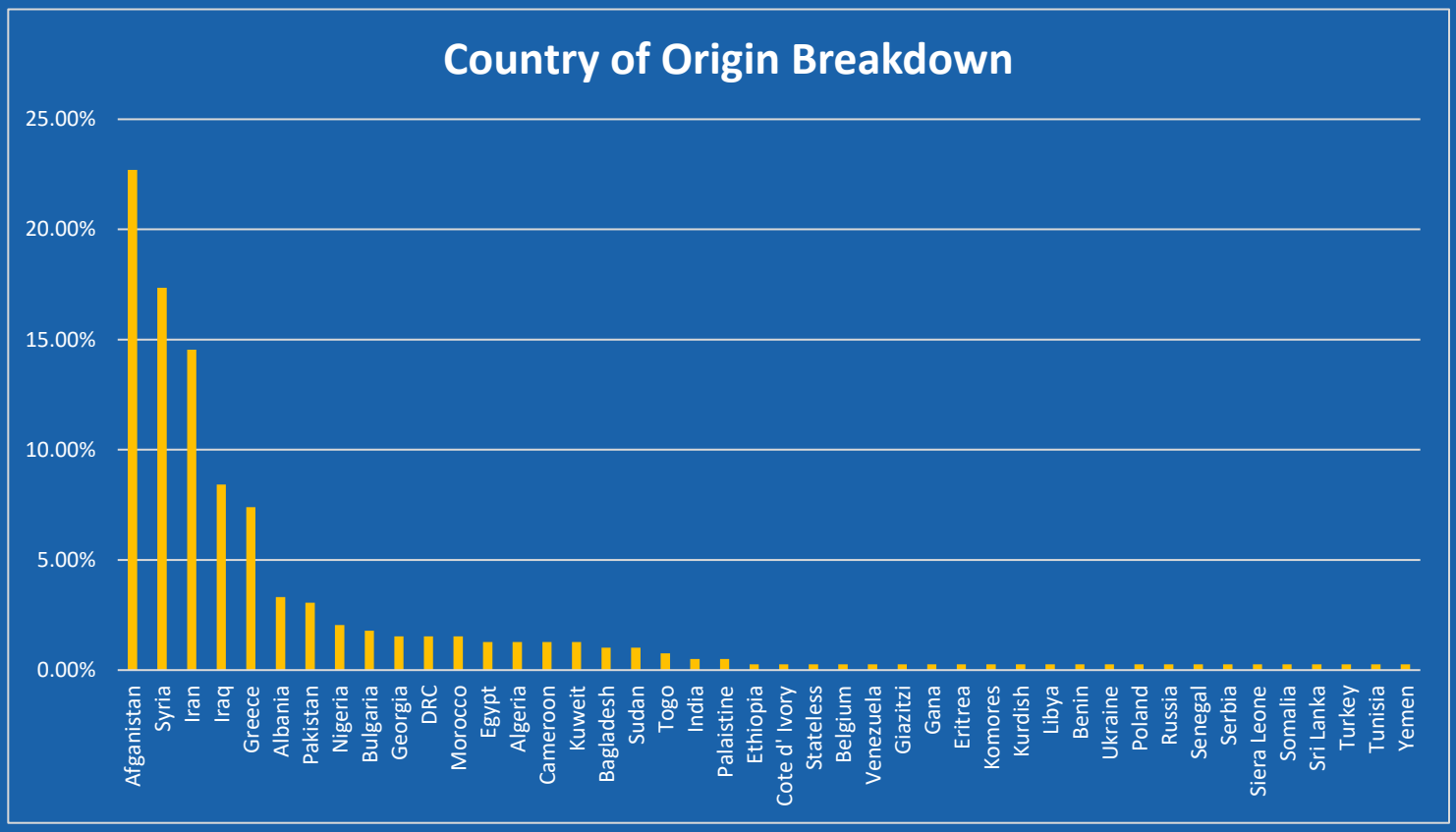
Beneficiaries during the 1st semester were 40% women and 60 % men. It is in the same scale with theprevious year of Open Minds implementation.



The majority of the beneficiaries were young men and women belonging in the working age population while almost 8% were adolescent.



The vast majority of the Open Minds beneficiaries originated from countries that are severely affected by war conflicts, while a noticeable percentage were Greek Nationals.



The language or the dialects varied due to the fact that the people were coming from more than 40 different countries all over the globe.

The Rwandan Prescription for Depression

"We had a lot of trouble with western mental health workers who came here immediately after the genocide and we had to ask some of them to leave. They came and their practice did not involve being outside in the sun where you begin to feel better, there was no music or drumming to get your blood flowing again, there was no sense that everyone had taken the day off so that the entire community could come together to try to lift you up and bring you back to joy, there was no acknowledgement of the depression as something invasive and external that could actually be cast out again. Instead they would take people one at a time into these dingy little rooms and have them sit around for an hour or so and talk about bad things that had happened to them. We had to ask them to leave."

A Rwandan talking to a western writer, Andrew Solomon, about his experience with western mental health and depression.[7]

References

[1]https://www.open.edu/openlearn/body-mind/health/cultural-differences-mental-health

[2] Idem

[3]https://www.uniteforsight.org/mental-health/module7

[4]https://books.google.gr/books?id=AP4HRH5G8RkC&pg=PA9&source=gbs_toc_r&cad=3#v=onepage&q&f=false

[5] https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2015.15101351

[6]Alonso J, Buron A, Bruffaerts R, et al. Association of perceived stigma and mood and anxiety disorders: results from the World Mental Health Surveys. Acta Psychiatrica Scandinavica. 2008;118(4):305–314.

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[7]https://underthebluedoor.org/2014/08/18/the-rwandan-prescription-for-depression-sun-drum-dance-community-we-had-a-lot-of-trouble-with-western-mental-health-workers-who-came-here-immediately-after-the-genocide-and-we-had-to-ask-some/?fbclid=IwAR3xD2XDljK75JOZcCoWhwtIyIm05KvmUBW2EBfnBwq2pHkKghkR5S5ho8Q

Open Minds Report

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