Between Worlds:
Interpreting conflict between black patients and their clinicians

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Executive Summary

Introduction

The Lambeth, Southwark and Lewisham Health Action Zone (HAZ) mediation project developed from a belief that differing views between black patients\(^1\) and clinicians leads to a situation where users refuse or are reluctant to engage with services. The main hypothesis of the project is that such differing views of illness and experience, and difficulties in communicating results in conflicts between black mental health service users and service providers and thus creates an unsatisfactory framework of care for black users. The project is structured as a mediation/consultancy service that can be used by clinicians or users of the service. Its aim is to offer a structured and positive way to communicate the different explanatory models between the parties concerned. It also looks at issues of language to explore whether misunderstandings and disagreement arise out of problems in communication. Alongside the mediation/consultancy service, the project also functions as a research base that explores current themes, debates, projects and policy within psychiatry, the social sciences, politics/government and the NHS.

Initially it was thought that there would be two divergent explanatory models at work: the patient’s (and sometimes their family’s) and their clinician’s. The project, therefore, intended to collect the information pertaining to these models and then try to negotiate between them to build upon common themes and to work with the differences. The goal of this project, therefore, is to try and offer a service that can create structured understanding between the differing cultural discourses – biomedical and non-medical.

This project believes that in order to accurately diagnose and treat patients from diverse backgrounds it is essential to consider the cultural meaning of somatic symptoms, and explore the social context of distress. Thus, this project uses the approach of medical anthropology to add information to the clinical encounter by putting a focus on culture, and the cultural constructions of mental illness at the forefront.

Background Rationale of the Project

A National Strategy for improving mental health services for black and minority ethnic groups in this country is long overdue. For over five decades now, there has been a concern over the way black and ethnic communities experience our mental health services. As Sashidharan (2001) outlines, “time and again, the mental health service experience of these communities has been shown to be discriminatory in nature, the outcome of most service interventions either unhelpful or inappropriate and the attitudes, ideas and practices within psychiatry largely working against their interests” (p.1).

\(^1\) In the following paper black is used to refer to people of African heritage (African Caribbean, African American, and African).
Although there has been ongoing concern about the experience of mental health services for black mental health service users and subsequent changes in the organisation and delivery, over the past fifty years there does not seem to be any improvements.

There is a considerable body of literature which shows that black people have a different experience of psychiatric services compared to the indigenous population. It has been argued that mentally ill British African-Caribbean are treated more punitively and are more likely to be ‘labelled’ with the stigmatising diagnoses of schizophrenia or cannabis psychosis because of racist attitudes among psychiatrists (Littlewood and Lipsedge 1981; Mercer 1984; Cox 1986; Littlewood 1988). On the whole, black people are over represented in compulsory admissions to the services, and those aspects of services where contact is coercive. Hospitalised black patients are two to three times more likely to be involuntarily patients under the Mental Health Act (Littlewood, 1992, see also Brown 1996; Ndegwa 1998) and it has been observed that excessive detention of individuals from the Caribbean was independent of diagnosis (Littlewood and Lipsedge 1989; Davies et al. 1996).

**Background Information: The Role of Medical Anthropology**

Medical anthropology is a branch of social and cultural anthropology and its main focus is on medicine, health and diseases and also how people from different cultures and social groups understand and rationalise about illness, health. Thus medical anthropology is situated both in a biological and social field of research. Medical anthropology is a discipline that is being incorporated within institutions and policy procedures. For example, within the NHS medical or ‘clinical’ anthropologists are becoming part of multi-disciplinary health care teams where their role is that of advising their colleagues on the importance of cultural factors when dealing with health and illness, or as therapists in their own right.

An anthropological approach to mental illness takes account of culture by looking at its effect on the self. Mental illness most often alters the core of the person. Thus, to better understand this process on an individual level we must look at how culture informs the very notion of the self. Understanding of oneself does not grow from an ‘inner’ essence relatively independent of the social world, but from experience in a world of meanings, images, and social bonds. Selves are not enduring, bounded, inner entities, but are a creation of acting and understanding which is derived from culture. Thus, there exist different varieties of selves and human subjectivity relative to the culture in which they are found. In many cases, mental health workers are approached with what are issues of identity and self. The notion of boundaries, ascribed identity, notions of self and the interface between these levels of experience are commonly present in cases of mental illness.

This project set out to use anthropological techniques to investigate the issues contained in the interaction between clinician and client. Anthropologists, who immerse themselves in the communities they study, in order to gain the in-depth knowledge they require, tend to use unstructured observation.
(participant observation) as a key part of their research method (or ethnographic study). Such qualitative research is fundamentally concerned with meaning, understanding and subjective reality. Qualitative research theory may emerge as the research progresses, that is the study structures the research rather than the other way around, giving rise to the notion of ‘grounded theory’. Thus, the study and its methods would develop and change as a result of our interactions and the subsequent findings. Qualitative methods arise from a different philosophical tradition, one which looks for meaning behind social action. This involves more than observing the social world, it requires interaction with the social world. The researcher becomes part of the process, in order to understand the symbolic nature of social action in the search for meaning.

In many ways qualitative methods are under-utilised in medical research. A wide variety of methods are needed to help us understand the complexities of human behaviour. Quantitative methods are useful, but we also need qualitative methods to understand the ‘why’. Thus, in light of the focus on quantitative approaches to looking at such issues, we focused on a more qualitative approach. Qualitative methods are particularly useful at this stage of the investigations into discrimination in the mental health service. This is because the question is no longer about over, or under, representation of black service users and other ethnic minority groups within psychiatry, but how such communities experience psychiatry. The question is also why such experience is largely negative and discriminatory in nature.

**LSL HAZ Mediation/Consultancy Project: A New Approach**

- The most important feature of this project, which sets it aside from other projects, is that while it is a research project, it is also an active attempt to improve mental health services. Only by actually trying to resolve problems in the system will we become aware of not only the real issues but also the appropriate responses to them.
- Instead of looking at large population samples it focuses on a small number of cases, but investigates these in depth (anthropological approach). Other projects which largely focus on quantitative analysis are unable to identify issues and themes that can only be found by way of qualitative research and analysis.
- These issues are identified by in-depth interviews with individual patients and their families, thus allowing the individuals to define the focus of the research. Unlike other research projects looking at similar issues, there is face to face contact with the informants, informants families and clinicians over an extended period of time.
- The researcher is embedded in the process and is able to observe themes as they unfolded.
- The researcher has a variety of roles which makes this project unique, such as, observer, researcher and advisor.
From Mediation to Cultural Consultancy Service

In mediation the third party is only there to elicit suggestions from the other parties. The project found that this was impossible due to the nature of a hospital setting. Often it was up to the researcher to make suggestions based on the information collected. In many cases the clients would not have had suggestions to make, thus, in many ways the project was working on a level that could not be accessed by mediation. For example, it was often focusing on explanatory models. The problem here is that people often do not know their own explanatory models. Thus, it was not the project’s role to elicit solutions from the clinicians and clients, but to gather information and either make suggestions or merely pass on the information. It was discovered that the service worked better along the lines of an anthropological consultation or cultural consultation approach. In this way it could find more information to add to the assessment and treatment of the individual. Seven months into the project, there was a deliberate methodological shift of focus from a mediation approach to that of consultation. This change resulted in more successful cases and a far better working relationship with service users and clinicians.

Methods

The first stage of this project was to do a broad based literature review which investigated various disciplines’ contributions to the issues raised by appropriate mental health care for black service users. The literature review drew from such varied fields as law, social sciences and medical literature in order to bring threads together which the project felt would be relevant to the project. The topics the project investigated included: racism; issues of race and culture in psychiatry; notions of insight; a review of the approach of medical anthropology, including a discussion of explanatory models; conflict resolution and mediation; and doctor-patient interaction. Throughout, the project continued to research many strands of relevant literature. As themes emerged during work with individual cases, the project added components to the literature review to incorporate these relevant themes. In addition to an ongoing academic review, meetings were also held with various groups and individuals who the project felt might add helpful advice and direction. These meetings were with user groups, patients, religious leaders, academics, mediators, and other health care professionals.

The project gained access to an individual patient or service user through referrals from the patient’s clinician or the nursing team on the ward. The individual could also contact the Project personally. Once the patient had agreed to meet with the Project the researcher would follow a format to gain information and knowledge on the patient’s cultural background and understanding of their illness (see below).

General Overview of Qualitative Approach

- The researcher interviewed the patient in an open-ended way, allowed the client to discuss the issues they felt were the most relevant and most
important. Also was able to be open-minded about the way they interpreted their illness experience.

- Took an in-depth history of their life experiences, important events, problems and about their family relationships.
- Spent more time with patient and family members, on average.
- Interviewed family members and friends, if possible to discover their understanding and explanations for the client’s problems.
- Embarked upon research for specific cases by speaking to individuals and groups outside the mental health service as well as researching relevant literature. For example, researched the person’s religious community to gain better understanding of their beliefs in context.
- Carried out participant observation in ward rounds.
- After seeing individuals and their family members/friends, the researcher produced a written report summarising findings whilst addressing certain issues and questions. By doing so, the researcher provided new information that most teams found useful, as the methods differed from the emphasis and the way information is collected in psychiatric services.

Findings

- The evaluations of the project by clients, their family members, and clinicians were largely positive.
- Use of the new consultation strategy instead of mediating models meant that the focus was on quick intervention, gathering information and conveying this at an early stage to the clinical team.
- The openness of the clinicians in certain cases to the ideas presented by the project made the process possible. The clinicians were able to question their assessments throughout, allowing themselves to use the information offered by the project. Clinicians involved seemed to take on board suggestions and comments and used them to alter their assessment and treatment regimes.
- The project was more successful when brought into at an early stage where the researcher could work as the process unfolded, before positions became entrenched.
- Some patients shifted around from ward to ward making it difficult to mediate.
- Often the patients’ concerns were beyond the scope of the role of the researcher. These concerns were usually about sectioning and medication.
- Difficulties arose when the researcher’s role was not clearly defined. For example, cases did not succeed when client felt that the researcher was too closely aligned with clinical team. Problems similarly arose if the clinical team felt the researcher was “on the side” of the client.

Future development of the Project

This project revealed that there is a definite need for services that improve the experience of care for black service users. However, the project also uncovered that there is a very real need to implement change on a large scale and to make such changes compulsory. It is important to note that as the
project drew to a close the amount of interest and referrals grew substantially. It is suggested that such a unique and new approach needs time to become known and it would appear that one year was not long enough to get the service off the ground satisfactorily.

Cultural Consultation Team

The service would benefit from having a small team working collaboratively with a variety of skills and backgrounds. The service would benefit from having at least one black team member, particularly to work with individuals who feel more comfortable with a black interviewer. The team should include the participation of experts in the medical culture of psychiatry who demand respect and authority from clinical colleagues. The team should also include individuals with expert knowledge of the culture(s) in question or possess the skills to investigate the individual’s unique beliefs and background. Having a team would allow for collaboration between individuals from a variety of disciplines and would also mean that team members could provide support for one another.

Training

- The most important and primary step should be adequate training of health care professionals to prepare them for such a service. For such a service to be a success, there needs to be a focus on educating clinicians and other mental health workers about the role of culture in mental health, medical anthropology and how to properly use and benefit from such a service.
- Preparation needs to begin on the meta level and include discussions about what culture, racism, discrimination and inequality mean.
- The researcher should be involved in the early stages of junior psychiatry training and such training needs to be compulsory and universal.

Policy

Improvements must also be made on the policy level:

- There is a need for mental health workers to adopt a more socially and politically informed role within the communities they serve.
- The mental health service needs to work towards building a unified approach to connecting clinical practice with cultural understanding. An emphasis must be placed on creating services which lead to equality of experiences and outcomes regardless of race and culture.
- There is a need to adopt a more strategic approach in order to tackle effectively the racial and ethnic inequities that persist in contemporary mental health practice. Such a strategy needs to be well-thought out, wide in its scope and enforced.
1. BACKGROUND AND RATIONALE

A National Strategy for improving mental health services for black\(^2\) and minority ethnic groups in this country is long overdue. For over five decades now, there has been a concern over the way black and ethnic communities experience our mental health services. As Sashidharan (2001) outlines, “time and again, the mental health service experience of these communities has been shown to be discriminatory in nature, the outcome of most service interventions either unhelpful or inappropriate and the attitudes, ideas and practices within psychiatry largely working against their interests” (p.1). Although there has been ongoing concern about the experience of mental health services for black mental health service users over the past fifty years, there does not seem to have been any significant improvements.

There is a considerable body of literature which shows that black people have a different experience of psychiatric services compared to the indigenous white population. (For a review of the subject see Fernando, Ndegwa, and Wilson 1998). In short, it has been argued that mentally ill British African-Caribbeans are treated more punitively and are more likely to be ‘labelled’ with the stigmatising diagnoses of schizophrenia or cannabis psychosis because of racist attitudes among psychiatrists (Littlewood and Lipsedge 1981; Mercer 1984; Cox 1986; Littlewood 1988). It has become increasingly apparent that a disproportionate number of patients detained in secure psychiatric facilities are of African-Caribbean origin (Murray 1996). On the whole, black people are over represented in compulsory admissions to the services, and those aspects of services where contact is coercive. Hospitalised black patients are two to three times more likely to be involuntarily patients under the Mental Health Act (Littlewood, 1992, see also Brown 1996; Ndegwa 1998) and it has been observed that excessive detention of West Indians was independent of diagnosis (Littlewood and Lipsedge 1989; Davies et al. 1996).

African Caribbean groups are also more likely to be detained with police involvement (Littlewood and Lipsedge 1989). They are over-represented in locked facilities and ‘special hospitals’ (Littlewood, 1992) and receive large doses of neuroleptic or tranquilising medication earlier on in their psychiatric career than their white counterparts. There is also evidence that they are more frequently given physical treatments such as electro-convulsive therapy independent of their actual diagnosis (Littlewood 1986; Littlewood and Cross 1980). They are over-represented among those who are the recipients of control and restraint measures and seclusion. Black and minority ethnic groups are also less likely to be referred for psychological therapies (Campling 1989). Anecdotally, black service users have also reported discriminatory and largely negative experiences of care. The message is unambiguous: minority groups are represented within

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\(^2\) In the following paper black is used to refer to people of African heritage (African Caribbean, African American, and African.)
psychiatric services in a different way, both quantitatively and qualitatively, from the white majority. Such evidence undeniably points to discrimination in the practices of psychiatric institutions in the U.K.

Recent reports have confirmed the familiar pattern of inappropriate and discriminatory service experience of black and minority ethnic groups. According to these reports, says Sashidharan (2001), “general dissatisfaction with mental health services by black and minority ethnic groups is persisting, despite attempts over the last twenty years to make mental health services more ‘ethnically sensitive’”. (p.1).

In the face of such recent reports, mental health care for black and ethnic minorities continues to pose a major challenge to politicians, policy makers, providers of service as well as those who use the services, their carers and our communities. There is a definite need to develop a specific strategy for minority ethnic groups. Many of these changes, however, will have benefits for all groups, in particular an emphasis on care and support, greater user and carer participation, an increased focus on community based options, improving social outcomes, combating stigma and marginalisation.

It would seem that the only agreement there is about ethnicity and mental health is that there is no aspect of contemporary mental health care where minority ethnic groups fare better or even as well as indigenous white people. Indeed, evidence suggests that in most instances they fare considerably worse than majority white population. Yet, in order to move forward we need to first and foremost agree what we are trying to remedy. Notwithstanding “any differences we might have in understanding the causes of current problems, we must work towards achieving justice and equity in service outcomes. What makes such an approach not only meaningful but also imperative in political terms is the requirement that is imposed on all public bodies and services in the wake of the Stephen Lawrence Inquiry and the imminent adoption of the Amendment Bill to the 1976 Race Relations Act” (Sashidharan 2001:3). As a result of the Macpherson inquiry, there is the requirement to appraise and change our day to day practice so that black and ethnic minority groups are no longer disadvantaged in comparison to white groups. The consequences of the new Race Relation Amendment Bill for mental health services are not fully understood, but it would appear that service providers will be required to eradicate ethnic differences in service outcomes.

Unless there is a positive service experience at the end of it, attempts to facilitate entry into services are bound to fail (Sashidharan 2001). Thus, this project focused on the actual experience of care and attempted to respond to the dissatisfaction of clients whilst they were in contact with the mental health service. However, the project also raised questions about other aspects of the mental health service which needs to be addressed. Sashidharan suggests, “this is a major problem at the moment and nowhere is it more obvious than in the
easy entry of black people, usually in crisis situation, to institutional settings and into aversive and extreme forms of care” (p.6). It would seem that it is in the institutional settings that black and minority ethnic groups have the worst experience of mental health care. Such negative experiences have a powerful bearing on any future relationship between the service user, his/her family and the care agencies, usually resulting in disengagement and a reluctance to seek voluntary access to care even when the need for this becomes obvious. Therefore, this project focused on trying to provide a more positive service experience so that the individual (and those around them) would feel more confident in accessing the mental health service if difficulties arose in the future.

It is clear that any attempt to improve mental health services for minority groups will have to start by addressing their negative experience within specialist, particularly hospital, settings. This project tried to do just that by investigating users’ experiences whilst in contact with care whilst simultaneously trying to improve that individual’s and their families experience of care.

The above mentioned findings set the scene for our project. Indeed, this undertaking has been developed in response to such conclusions which point to vast inequalities between experience of care and the care offered to the white population and to the black population. Our project is an exploratory exercise which explores the issues involved and attempts to find possible solutions to the situation.

This project comes from a belief that differing views between patients and clinicians lead to a situation where users refuse or are reluctant to engage with services. The service providers then have negative views of users and this leads to a state where services can only be provided in a coercive manner. Psychiatrists tend to be strongly welded to their model, which is predominantly a eurocentric model, of assessing a user’s presenting problems and deciding what interventions to offer. Users feel that their models, construction and experience of their problems are not taken into account. This is particularly relevant for users from ethnic minorities like the black population who are typically described by psychiatrists as lacking insight. A better approach might be to see this situation as a breakdown in communication resulting from a failure of the psychiatrist to take account of the user’s construction and framing of their problem. The main hypothesis of the project was that such differing views of illness and experience and difficulties in communicating result in conflicts and dissatisfactory care amongst black mental health service users.

Our main approach was to apply medical anthropological theories to the clinical encounter. Culture shapes experience and expression of emotional distress and social problems in a myriad of ways (Kirmayer 1989). In order to accurately diagnose and treat patients from diverse backgrounds, therefore, it is essential to consider the cultural meaning of somatic symptoms, and explore the social context of distress (Kleinman 1988; Mezzich et al. 1996; Rogler 1993, 1996). A variety of models have been developed to meet this clinical challenge. These
range from ethnospecific mental health services or clinics (e.g. Kinzie *et al.* 1980), to the use of culture brokers and specifically trained mental health translators, to the training of clinicians in generic cultural competence. This project was an attempt to establish and investigate a new approach and to look at the feasibility of such a strategy.
2. LITERATURE REVIEW

The literature review was intended to be a broad-based approach to the various elements of the ‘problem’ of appropriate mental health care for black service users. We wished to gain an understanding of the ways in which different disciplines might approach such issues. Thus, we drew literature from such varied fields as law, social sciences and medical literature. We investigated different approaches from different disciplines and tried to thread these themes together. Issues which are relevant to our endeavour will be discussed below, including: issues of race and culture in psychiatry; notions of insight; a review of the approach of medical anthropology, including a discussion of explanatory models; conflict resolution and mediation; and doctor-patient interactions.

Psychiatry

Personal misfortune and distress are increasingly experienced though a medical lens “which encourages us to understand and shape our troubles in a clinical way: as something like a disease which suddenly constrains us from outside our intentions” (Littlewood 1996:245). Some people, however may resist a medical reading of their experiences. Littlewood notes that we need to pay attention to psychiatry’s own culture in order to understand patterns of psychological distress not simply as biological changes “which appear from beyond our awareness until they are diagnosed but also as part of meaningful experience and action- as what we might term cultural patterns” (1996:246). Such an analysis of the culture of psychiatry would include an emphasis on the historical origins and politics of its nosologies, to its clinical engagement with its subjects, and indeed to its very understanding of culture.

As a biomedical discipline, psychiatry is somewhat compromised in not having its ontological roots well articulated and validated. Despite their abstract nature, indicators of illness cannot be said to refer to impersonal and technical attributes of a body, but to highly personal components of the self since they implicate beliefs, intentions and modes of thinking and feeling (Fabrega:1989). Whereas diseases in general medicine and in surgery are about the body and indirectly about the self, disease accounting in psychiatry is a direct commentary on the self and of the self (Fabrega 1989a, 1989b). Furthermore, to the extent that psychological experience and social behaviour together compose the self, and putative psychiatric disease mechanisms directly alter such a composite in a compelling way, to diagnose psychiatric disease is of necessity to qualify the self medically. Psychiatric diagnosis, then, necessarily entails a medicalization of social and psychological behaviour in a way medical and surgical illnesses do not (Fabrega:1989).

Fabrega (1989c) has outlined the way in which special social and cultural problems characterize the rationale and practice of contemporary biomedical psychiatry. The problems of psychiatry are further “energized by the mode of
operation of modern, complex industrialized societies wherein bodies and minds are said to be subject to surveillance, regulation, and control, all under the guise of the pursuit of health (Foucault 1965, 1979; Scull 1979). An outcome of the evolution of medicine has been a subtle and more powerful form of bodily control through the creation of an ever more technical and abstract language of disease that allows diagnosis and treatment to move away from the self and its social connections. Modern medicine attempts to render disease as the impersonal essence of an object that ethnomedicine shows is rooted in social, moral, and existential concerns. The evolution of modern medicine and surgery have “served to move them away from directly implicating the self socially and politically, and psychiatry seems to want to follow suit, but is not fully successful. Biomedical psychiatry thus affords a potentially rich topic for ethnomedical enquiry” (Fabrega, 1989c: 168).

In the political economy and structure of modern society, moreover, “corporate psychiatry becomes involved in the deliberations of other corporations and institutions having patent social control functions. Here, its knowledge and pursuits affect and reflect how that society operates. In carrying out its institutional/corporate functions and in medicalizing the behaviours of actors, it can overlook the individual’s needs, exculpate or depoliticize their actions, and stigmatize them or otherwise label them in ways that undermine their social credibility as well as responsibilities as citizens” (Fabrega, 1989c:169). As the authors continues to state, “what needs emphasis is how the ideology and rationale of surveillance and disciplinary control, which operates through state-influenced institutions and corporations…comes to bear on personal crises involving psychiatric illness, how it influences the work of the psychiatrist, and the way in which such crises are played out socially” (Fabrega, 1989c:181).

**Racism and psychiatry**

Authors agree that racism is a notoriously difficult concept to define. Miles (1989) refers to racism as an “ideology that defines social collectivities in terms of ‘natural’ and immutable biological differences, which are then invested with negative connotations of cultural difference and inferiority” (in Back 1996). The Macpherson report (Home Office 1999) states that “racism in general terms consists of conduct or words or practices which disadvantage or advantage people because of their colour, culture, or ethnic origin. In its subtle form it is as damaging as in its overt form” (p.20). Such a definition is extremely pertinent as it connects racism with culture. Jones (1972) delineates three primary forms of racism: individual, institutional and cultural, all of which overlap and interact with one another (in Harrell 2000). An individual will experience racism often as an experience with all of these forms. The individual form is a belief in the inferiority of a racial and/or ethnic group, whilst the institutional form describes systemic oppression and exploitation. Cultural racism encompasses ethnocentrism and status quo maintenance.
This project is particularly interested in institutional racism as this has increasingly been seen as a major problem within British psychiatry. Although the debate about race and psychiatry is as old as psychiatry itself, in the past three decades psychiatric institutions and practices have come under critical scrutiny for their racial bias. As Sashidharan (2001b) suggests, “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” (p.244). There is some urgency in addressing the extent and nature of racism within British psychiatry and this need has been made somewhat easier by the publication of the Macpherson report (Home Office 1999). This report had far reaching conclusions about institutional racism within public bodies in the UK and has made it easier to talk about race and racism (Sashidharan 2001b). This Inquiry into the death of Stephen Lawrence started a learning process for the country at large and, in the course of it “the gravitational centre of race relations discourse was shifted from individual prejudice and ethnic need to systemic, institutional racial inequality and injustice” (Sivanandan 2000).

Institutional racism is not a question of individual acts of racism, but instead, is part of the fabric of the organisation in which those individuals work. Indeed, it would seem that the organisation itself constrains behaviour to these ends. As Dr. Oakley is quoted in the Macpherson report, “the term institutional racism should be understood to refer to the way institutions may systematically treat or tend to treat people differently in respect of race. The addition of the word ‘institutional’ therefore identifies the source of the differential treatment; this lies in some sense within the organisation rather than simply with the individuals who represent it. The production of differential treatment is ‘institutionalised in the way the organisation operates’” (p.27). The Macpherson report applies the following concept of institutional racism: “The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people” (p.28). Research has highlighted the institutional dimensions of racism.

It would appear that there is now a sense of urgency in combating racism in public bodies such as the police and the NHS, largely due to the Stephen Lawrence case and the subsequent inquiry. For the first time in many years “it would appear that there exists a political climate that allows us to acknowledge the existence of racism not just at the personal level but also as an institutional problem. In many ways the Macpherson report has set down a defining marker in the discourse about race and racism in this country” (Sashidharan 2001b: 244). Sashidharan contends that given the government’s modernising agenda for the NHS with an emphasis on equality and fairness, psychiatry will have little choice but to talk critically and openly about race and racism. Similarly,
psychiatry must respond to the charge of institutional racism and think of new ways to combat inequality within the services it provides and the outcomes it subsequently creates.

It is extremely likely that there will be an amendment to the Race Relation Act of 1976 which will make it incumbent upon all public services to root out indirect as well as direct discrimination. Thus, mental health services will soon be obliged to respond to the overwhelming evidence which attests to the discriminatory nature of psychiatric care in this country. NHS psychiatric services will finally have to listen to what Black and ethnic minority clients have been saying, “that there is something fundamentally wrong with the practices, procedures and underlying assumptions of psychiatry and that modern British psychiatry is, like many other public institutions, imbued with racism” (Sashidharan 2001b:245).

Racism and psychiatry have been linked in the public imagination, largely because psychiatry has often been seen as a tool of the state and an instrument of social control. Psychiatrists have been encouraged to detain people who appear to be a threat to themselves or others- thus being 'saved' from themselves or ‘saving’ others (Bhurga and Bhui 1999). Racism in psychiatry is often cited as the mediating factor in cases of misdiagnosis and mismanagement in psychiatry. Misdiagnosis includes both over-diagnosis and under-diagnosis and differences in management include factors such as differences in medication offered, as mentioned above. Lock (1993) suggests that race be seen as a politically motivated category, as a social label or category rather than as a biological fact.

The problem of racism in psychiatry must be seen as running far deeper than individual practices and prejudices. The roots of racism in psychiatric care can be traced to the conceptual and theoretical framework of what constitutes modern psychiatry (Littlewood and Lipsedge 1982; Fernando 1988). Anthropology, can provide a critique of such practices by showing psychiatry as a cultural construct with its theoretical and historical roots innately important to its modern configuration. Our approach is to apply anthropological methods to the problem of conflict between black patients and their clinicians to broaden the context under analysis. The importance of anthropology, say Lewis-Fernandez and Kleinman (1995), is that it tests the validity of western psychiatric categories for the cultural setting under study.

Mainstream psychiatry and epidemiology have been criticised for ignoring validity while searching for reliability (Kirk and Kutchins 1992; Nations 1986). Within psychiatry there is still a reluctance to acknowledge that psychopathology arises at the interface between the brain and social experience (Eisenberg 1995). This is very likely due to psychiatry’s struggle to be seen as a “hard science” like other disciplines in medicine. As a result of this struggle to belong within medicine, psychiatry is consumed with the development of a universal system of diagnosis and classification (Fabrega 1994). Inherent in this approach is that the universal
classifications will transcend cultural difference (Gellner 1992). However, because of the interface between biology and society the practice of psychiatry cannot be seen in isolation from the social experience of its clients (Hutchison and Hickling 1999).

People from ethnic minorities, particularly those who are black, experience a variety of practical disadvantages, such as in the areas of education, employment, housing and health. And such disadvantages along with experiences of racism impact on their mental health and can result in higher representation of black people in mental health services. Young and Ndegwa (in press) propose that the notion of racism can be seen as a form of chronic stress and that negative mental health outcomes, particularly psychosis, can be more than just an indirect consequence of such stress in the African-Caribbean population. Higher representation can also be seen as partly due to the fact that they can experience racism and a lack of understanding of cultural differences when they enter the mental health system itself (Mind 1993; HMSO 1994; GPMH 1995; MIND 1997). Ample evidence has accumulated, especially over the last few years, “to show that to be black in Britain today is to be exposed to a variety of adverse stimuli which can add up to a quite serious hazard to mental health” (Littlewood, 1992). What many doctors and social workers “take as unintelligible’ and thus ‘insane’ may, at another level of understanding, be seen as legitimate and coherent human responses to disadvantage and racism” (Littlewood 1992:4).

As Littlewood (1980) suggests, to recognise this situation is not to see black Britons as helpless pawns, but to recognise that their lives are lived through and against such overarching structures. Ethnic or racial inequalities in health care and delivery merely reflect the inequalities of the social setting (Stubbs 1993). The National Health Service (NHS) “as a public treatment system reflects the ideology and inequalities of the society as a whole and this is especially so of the psychiatric services which act as the guardian of a society’s mental health and order” (Hutchinson and Hickling 1999:164).

Although referring specifically to psychotherapy, Littlewood’s (1992) call for a closer look into social control can be extended to the practice of psychiatry. The question is, “control of whom, by whom and for what end? We need not simply ‘therapy’, but a self-reflexive practice which examines its own prejudices, ideology and will to power, which is aware of the ironies and contradictions in its own formation, and which is prepared to struggle with them” (Littlewood, 1992:13).

As Fernando (1988) asserts, psychiatric research in Britain tends to ignore or marginalise social experiences of blacks and ethnic minorities. Research “based on these groups is perceived as being applicable to those groups alone, while research based on white people is incorporated into mainstream psychiatry as being applicable to everyone” (Fernando 1988:54). Thus, one must be careful in establishing special services for black people as long term solutions. The establishment of such services may be a useful short term, stepping stone to a
more fair service for everyone. But we must be careful not to merely reinforce a racist model which sees black people as requiring an approach which would ‘educate’ them into white norms. (Fernando 1988). Similarly, we must not see issues such as ours as merely an anthropological issue.

It should be noted that physicians themselves are also part of a ‘folk’ world for most of their lives, both before and after medical school. They are members of a ‘folk’ world as both individuals and as members of a particular family, social class, or religion and they bring with them a specific set of assumptions, ideas, experiences, prejudices and inherited folklore (Helman 1994). The attributes a physician has as part of a ‘folk’ world can greatly influence their medical practice. One of the integral aspect of our project is the interviewing of the clinician in order to elicit a better understanding of why they behave as they do and to understand why it is they approached the illness of the particular patient in the way they did.

Within psychiatry observations and research findings are usually analysed “by examining the extent to which feelings, behaviour, social conditions, etc. deviate from norms and or cause distress” (Fernando 1988). It is in this way that diseases are recognised, measured and diagnosed and that the aetiologies of these diseases are evaluated. This scientific methodology that psychiatry has adopted has allowed it to gain a certain respect in medicine and in society as a whole. However, the “subjectiveness of the information-gathering process in the discipline, quite apart from other factors (such as resistance to change, the need for respectability and economic pressures), lays it open to influences from social and political forces” (Fernando 1988:47). Designating psychiatric categories is characterised by lack of precision and objectivity and this, in turn, results in slippage of meanings. Categories can easily slip into stereotypes, making psychiatry comfortable with dealing with and in stereotypes. Fernando (1988) further asserts that stereotypes present in society at large are incorporated into the psychiatric ‘machine’; by being “incorporated into a supposedly scientific body of knowledge beliefs based on stereotypes become ‘facts’. They, in turn, become institutionalised to become myths” (Fernando 1988:48). Psychiatry is not outside the society within which it functions and is more vulnerable to absorbing aspects of culture than other institutions such as law or education.

In psychiatry, more than in other disciplines of medicine, “prejudice’ is asserted to explain variations in the management of ethnic minority patients” (Bhurga and Bhui 1999:236). The problems of bias in regards to the therapeutic process has been explored in recent years in relation to therapist factors including ignorance, prejudices and countertransference (Holmes 1992). It has been observed that the relationship between clinicians and patients across cultures often ignores variables such as past contact with other cultures, experience with other cultures, and socio-economic status (Bhurga and Bhui 1997). Such studies can be seen as descending from a much earlier work which looked at the concept of ‘distance’. The Boganda Social Distance Scale (1967) found that those who felt
more comfortable with ethnic minorities usually had a higher case load of ethnic minority patients.

A position has emerged in which some White psychiatrists, Black psychiatrists and even some patients profess to be ‘colour blind’ (Ayonrinde 1999). The author asks whether this guise of equality denies reality. Indeed, Simpson (1993) emphasized that ‘in claiming that we are all the same we take away any special differences that we may have’. Furthermore, claiming that we are all the same results in an ignoring of the fact that black people’s experience of the mental health service is simply not the same as those of the indigenous white population. As Ayonrinde (1999) suggests, there exist a paradox in which these differences which appear to cause so much trouble to the psychiatric process of curing fractures in identity and self are in fact essential for our sense of self esteem and identity. The first step, therefore, in attempting to deal with racism in psychiatry is to recognise its existence (Bhurga and Bhui 1999).

The current ethos in psychiatry is that opinions voiced by people seen as leaders in the profession are given precedence and the opinions of others are discounted (Fernando et al. 1998). The authors continue to suggest that the result is that “views which dissent from those of established people are construed as subversive or ‘political’ and thus marginalised” (Fernando et al. 1997:221). Furthermore, there is a tendency to regard psychiatry as a science which has moved beyond the point where qualitative approaches which attempt to address the question ‘why’ are irrelevant. Thus, psychiatric research continues to focus on quantitative methodologies which are applied uncritically to all sections of the population (Fernando et al. 1997). Thus, this project will focus primarily on qualitative methods in order to investigate the ‘why’ of the poor experience of care amongst the black population.

**The Notion of Insight: Compliance and dismissal, a tool to maintain power and authority.**

In the psychiatric literature it is widely accepted that insight in a clinical modulator of compliance with treatment and a good indicator of prognosis (McEvoy et al 1989; Buchanan 1992; Kemp et al 1996). Insight is a quality which has been highly valued by most clinicians in the mental health field, largely because a strong link is assumed between good insight and greater quality of life (McGorry and McConville, 1999). Yet, insight is a complex construct which has been left largely unproblematised. All too often, “the term has been used as shorthand for the degree of congruence between the explanatory models and views on the mode and conditions of treatment of the clinician and the patient” (McGorry and McConville, 1999: 131). For these reasons, our project is interested in the concept of insight in that as a label, low insight may point to a lack of agreement about the illness, between patient and clinician. For example, an individual who has a very clear understanding of what their illness/problem is may be considered to have low insight if they do not share the same explanatory model as their clinician.
David (1990) contends that there are three overlapping dimensions to insight: the recognition by the patient that they are suffering from a mental illness, a compliance with treatment, and an ability to re-label unusual mental events. Thus, we can see that compliance with treatment and the agreement with one’s clinician is tightly bound to the notion of insight. Indeed, “re-labeling” unusual mental events would mean coming in line with psychiatry’s labeling of abnormal and unusual experiences and seeing the experience as resulting out of mental illness and dismissing all other explanations. Insight has been associated with greater expressed willingness to take medications (McEnvoy et al. 1981) and with better adherence to prescribed medication (Lin et al. 1979). Studies such as McEvoy et al. (1981), Lin et al. (1979), Van Putten et al. (1976), and Heinrichs et al. (1985) reveal that the connection between insight and acceptance of medication can not be simplified. From these findings David (1990) asserts that it is recommended that “drug compliance and awareness of illness be regarded as separate though overlapping constructs which contribute to insight” (p. 800).

David himself acknowledges that the predictive value of insight for outcome is ‘probably mediated through medication compliance’ (Kemp and David 1996). The notion that insight is a multi-dimensional construct has been supported empirically by Zimmerman 1991; David et al 1992; and Birchwood et al, 1994. Greenfeld et al. (1989) also conclude that insight is a multi-dimensional construct and have outlined that it consists of five independent components: symptomatology, the existence of an illness, etiology, vulnerability to relapse, and value of treatment (McGorry and McConville 1999).

As Beck-Sander (1998) suggests, the composite dimensions of insight are differently defined by different authors, giving rise to different kinds of insight. Such different definitions lead to a confusing situation in which accurate communication is hindered. Beck-Sander adds that, “clinicians may be vague about the specific components they are referring to when describing a client as ‘insightful’. They may mean ‘treatment compliant’, ‘aware of symptoms’, ‘attributes symptoms to medical disorder’ or any combination of these and other constructs” (Beck-Sander 1998:585).

Measurements of insight could be largely affected by the patient’s ability to put into words their views on these complex and ambiguous issues (David et al., 1992). Thus, it is possible that these measures might indirectly measure IQ rather than insight (David et al., 1992). There is also the problem of circularity in these measures; “if questions regarding compliance are an integral part of an insight rating, it is invalid to use insight as a measure of (stated) compliance” (David et al., 1992: 599). It follows that the notion of insight is dependent upon shared notions of illness between clinician and patient and upon the ability of the patient to communicate their experience in an understandable way to the clinician. Thus, one can see insight as a form of control, a way of dismissing patients who resist the clinicians model for their illness.
David (1990) and Amador et al. (1991) seem to assume that “loss of awareness of deficits and denial of illness are primarily a product of whatever disease process underlies psychosis, and they discuss ways of understanding insight in neuropsychological, cognitive, and philosophical terms” (Johnson and Orrell 1996: 1081). However, these discussions leave out one potentially important influence: social and cultural factors. Patients may disagree with their clinicians’ views that they are ill not as a result of the illness itself, but because they hold different beliefs about the nature of mental illness. Thus, the discussion of insight can be problematised by introducing the concept of culture and of explanatory models. As Beck-Sanders suggests, the inclusion of explanatory models “goes to the heart of many concerns about the usefulness of the global construct of insight” (1998:587). She asserts, that despite correlations suggesting general tendencies toward favourable outcomes such as ‘better prognosis’ or ‘treatment compliance’ in individuals with higher levels of insight, considerable variation remains. Furthermore, if the needs of the client group are to be met, these individual differences cannot be ignored.

Many cultural groups see mental illness as highly stigmatising, thus, it can be seen that denying one is mentally ill may be a method of coping. There is some evidence that patients may protect themselves from the stigma of mental illness by denying that they are ill (Johnson and Orrell 1995; McGorry 1992; Lally 1989; Kennard 1979). Thus, it is possible that individuals deny that they are ill not as a result of the illness, but as a conscious attempt at protection. Likewise, denial of illness may be associated with fear by the patient of the kind of treatment offered by psychiatrists among certain ethnic groups (Johnson and Orrell 1996). Loss of insight “could be seen as a way of coping where the patient finds the implications of a diagnosis of mental illness or the prospect of treatment very unacceptable” (Johnson and Orrell 1996:1084). This factor is particularly relevant for the Afro-Caribbean community who are (justifiably) fearful of psychiatry and the treatments offered.

Johnson and Orrell (1996) suggest that it is possible that psychiatrists’ ratings of insight are influenced by their own biases and expectations. The authors further suggest that this conclusion could be supported by the findings of Lewis et al. (1990) where it was found that patients’ ethnicity appears to influence psychiatrists’ assessments of psychotic patients. The suggestion is that psychiatrists need to be aware of their preconceptions and understand the way in which these influence their discussions with their patients about illness and treatment and that there needs to be a more sociocultural view of the basis of insight (Johnson and Orrell 1996). Thus, we have seen that when one introduces the concept of culture and explanatory models into a discussion of insight, the notion itself becomes problematised. Thus, in our project we will look at the individual’s “insight” as it is defined by the clinical team involved and look at its relationship with divergent explanatory models.
The Approach of Medical Anthropology

In what way can anthropology contribute to the problems outlined above: those of the relationship between race, culture and psychiatry? There has been an increasing role of anthropologists within the clinical context. Anthropologists and clinicians have been jointly committed to improving the quality and efficacy of care. As Swartz (1983) states that practitioners “need to develop better understanding of the factors that affect an individuals’ perception and response to health, illness and therapy…[anthropologists] can increase the understanding and anthropological concepts in the activities of traditional providers of health care” (p.17). Thus, a key issue in medical care has become the cultures of particular groups of people (Weidman 1983) and anthropologists have been the obvious profession to turn to. Therefore, in psychiatry the psychiatrists are concerned “with knowing about the signs and symptoms of suffering, about how these are expressed and how they can be treated. Anthropologists are concerned with developing a framework which is sufficiently receptive to embrace and comprehend the sense which people themselves make of their suffering” (Krause 1994:278).

In order for a consultation to be success, there must be a consensus between the two parties (doctor and patient) about the cause, diagnostic label, prognosis and optimal treatment for the condition (Helman 1994). The search for a consensus, for an agreed interpretation of the patient’s condition, has been called ‘negotiation’ by Stimson and Webb (1975). Individuals will strive for a diagnosis and treatment which ‘makes sense’ to them in terms of their lay views of ill health. Helman (1994) has isolated a number of recurrent problems in the negotiations between doctor and patient. Differences in the definition of ‘the patient’ may result in problems in the therapeutic process. An inappropriate “focus only on the individual and his or her symptoms, while ignoring wider familial, social and economic issues may make both a consensus and solution to the problem difficult to achieve” (Helman 1994:137). Two of the common sources of difficulty in reaching consensus are the misinterpretation of languages of distress and incompatibility between the explanatory models at work. Thus, this project will focus on these two main issues and investigate their role in conflicts between clients and psychiatrists in the setting of South London and the Maudsley.

Looking at culture and illness in a more specific way, Obeyesekere (1985) discusses the resonances between aspects of experience and culture. The way that symptoms are put together and “given cultural meaning or symbolization is intrinsic to their nature as illness/disease. The conception of the disease (i.e., illness) is the disease” (p136). Integral to the approach of medical anthropology is the distinction between disease and illness (Fabrega 1972). This construct is crucial for clinically applied anthropologists. This seminal idea is related to a relativist point of view and “is crucial for the anthropologist who is trying to demonstrate how elicitation of patient perspective is critical to culturally sensitive
Illness being the “subjective response of an individual, and of those around him, to his being unwell; particularly how he, and they, interpret the origin and significance of this event; how it affects his behaviour, and his relationship with other people; and the various steps he takes to remedy the situation” (Helman 1994:107). Illness also involves the meaning an individual gives to their experience. The meaning given to their symptoms and their emotional response to them are influenced by their background and their personality as well as the social, cultural and economic context in which they appear. As Lewis-Fernandez and Kleinman (1995) explain, illness is as much a cultural category as language. Both are deeply influenced by biologic parameters, but they are also created in diverse ways by local social formations. Disease, is tied to the perspective of sickness that refers to some biophysical abnormality that can be objectively demonstrated by Western scientific means. The concept of an explanatory model (Kleinman, Eisenberg and Good 1978), as described below, aids in concretizing the disease-illness distinction for clinicians (Chrisman and Johnson 1986).

There is a need to see illness as communication in some situations. To express adequately our “experiences to others in our community we have to be able to perceive the world symbolically in a standardized manner...Confusion in communication arises if we are trying to describe experiences for which there is no acceptable code or when we are uncertain which is the proper code to use” (Littlewood 1997:219). Other social groups may attach a different meaning to our signals or even fail to notice them and such a situation is heightened if we are in a social group who is not familiar to us. To complicate matters, a person may be moving from a culture which largely shares symbols to a culture where an emphasis on individualisation means symbols are not commonly shared.

People we call mentally ill often use a private symbolism which is not readily accessible to others. The more “uncommon our experiences, the more difficult they will be to communicate to others, and schizophrenic patients usually employ highly idiosyncratic symbolic communication.....Symbols are always ‘overdetermined’- they refer to many different things and we have to be constantly aware of their subtle ambiguities” (Littlewood 1997:219). As Littlewood notes, mentally ill individuals do not always invent their own system of symbolic communication. Mentally ill people often employ the dominant system which others use, but are likely to do so in a way which seems inconvenient and clumsy to others (see Weinstein, E. (1962) Cultural Aspects of Delusion New York: Free Press).

An anthropological approach to mental illness further takes account of culture by looking at its effect on the self. Mental illness most often alters the core of the person, thus, to better understand this process on an individual level, we must look at how culture informs the very notion of the self. Understanding of oneself does not grow from an 'inner' essence “relatively independent of the social world, but from experience in a world of meanings, images, and social bonds” (Rosaldo,
Selves are not enduring, bounded, inner entities, but are a creation of acting and understanding which is derived from culture. Thus, there exist different varieties of selves and human subjectivity relative to the culture in which they are found. Krause (personal communication, 1998) suggests in reference to a particular case study, that what makes a person better is not necessarily what was wrong with them in the first place. In many cases, mental health workers are approached with what are issues of identity and self. The notion of boundaries, ascribed identity, notions of self and the interface between these levels of experience are commonly present in cases of mental illness. Thus, one must take special care to understand the way in which these states are understood, interpreted and experienced by the individual. A psychiatrist who assumes a certain notion of self, of boundaries and of ascribed identity will often fail when confronted with a patient who does not share his or her beliefs.

Among Europeans, and such is the basis of psychiatry, the aetiology of psychological illness is characteristically located within the individual. This model differs from many non-Western and minority cultures where either supra-individual powers or social relationships are commonly cited as causal (Kleinman 1980; Marsella and White 1982; Littlewood and Lipsedge 1989). As Littlewood and Lipsedge (1982/1997) and Mercer (1986) have argued, the approach of psychiatry is an emphasis on the individual, in which questions of intergroup relations and economic power are reinterpreted though a focus on the individual as victim. Psychiatrists have argued that minority patients come to treatment later and more reluctantly as a result of their stigmatisation of mental health problems (Morley et al. 1991; Littlewood 1993). As Lipsedge (1993) suggests, society’s perception of minorities may impair service delivery to black and ethnic minority users. Thus, Callan and Littlewood (1998) argue that racial perceptions rather than cultural difference is significant.

Anthropologically informed studies are not limited to folk healing; psychiatric inpatient, outpatient, emergency, and rehabilitation services are also receiving research attention, as in the impressive ethnographies of Rhodes (1991), Estroff (1981), Nunley (1995), Ortiz (1994), Ware et al. (1992), Desjarlais (1994) among others. These studies show how cultural, institutional and political processes influence the practice of psychiatry and the experience of care (both the patient’s and the physician’s). There have also been recent works which investigate how knowledge is socially produced in psychiatric research and how psychiatrists are trained (see Good 1994).

Rather than seeing ethnic diversity among patients as the “sole stimulus to culturally sensitive care, we hope that this type of care would be used with every patient” (Chrisman and Johnson 1986:101). One of the major battles for “clinically applied anthropologists is to assert continually that cultural data and a culturally sensitive approach are relevant to all patients, not just those whose ethnic background happens to be different from the practitioners” (Chrisman and Johnson 1986:101). Interpretive or hermeneutic approaches have been
proposed by several medical anthropologists. Katon and Kleinman have suggested that even clinical encounters between members of the same cultural group can be analyzed in terms of translation process involving mediation between professional or biomedical interpretive frameworks (Katon and Kleinman 1981).

Linda Alexander (1979) and Howard Stein (1980a) point out that anthropologists working in the clinical setting must be careful of the tendency to be advocates for patients, families, or specific ethnic groups. Such a tendency leads to a focus on the power differentials between doctor and patients, and a reflexive bashing of physicians. The anthropologist must also be wary of introducing all information from the patient’s perspective because this contradicts the strongly held position within anthropology of holism (Chrisman and Johnson 1986). For Alexander, the advantage of the anthropological approach of holism is that it forces the anthropologist to take a systems perspective of the clinical setting. When they are “able to stand back and analyze the entire system, both clients and clinicians stand to gain...frequently the anthropologist’s assessment and intervention at a systems level can create many new options for treatment” (Chrisman and Johnson 1986:98). A holistic perspective will be particularly relevant in our project as it has the “practical advantage of reducing the chance of alienating clinical colleagues by appearing to favor one side or the other” (Chrisman and Johnson 1986:98).

Anthropology has been associated with psychiatry for some time, mainly because the role of culture is most striking in this discipline of medicine. One of the most difficult problems for clinicians and anthropologists is deciding whether culture is playing a role in the health problem or its presentation to a practitioner (Stein 1985c). What is of importance for this project is medical anthropology argues that medicine is not outside of culture, instead, it is a cultural construct no less than other aspect of our world view (for a detailed account of the culture of psychiatry see B. Good 1994).

As in any discipline, there are a number of schools of thought within medical anthropology. There is not the scope to explain these movements, but there have been a few new developments which are integral in situating our project. Adopting an orientation that addresses both local and global power relations, Morsy (1996) discusses the political economy orientation in medical anthropology. The author describes such an orientation as an expression of a more general, politically informed, historical development in the parent discipline. Anthropological political economy prioritizes embedding culture in historically delineated political-economic contexts. Specifically relevant in regards to our pursuits, such an approach sees the relevance of culture not restricted to ethnomedical conceptions but extends to issues of power, resistance, control, and defiance surrounding health, illness, and healing (Comaroff 1985; Morsy 1978, 1993a; Schiller 1992). Thus, culturally meaningful constructs are examined in their sociohistorical context (Morsy 1996). Epistemologically,
medical anthropologists explicitly acknowledge that both anthropological and medical knowledge are socially informed products of a particular historical and cultural contexts (Morsy 1993; see also, for example, Martin 1987; Taussig 1980; A. Young 1980; 1988). Thus, our aim is to bring into focus the social context of the patient and of the patient-consultant encounter.

Lock and Schepher-Hughes (1996) offer a unified paradigm which challenges the discipline to reconcile the divide between the above-mentioned political economy approach with the culturological perspective. They offer the critical-interpretive approach which recognizes the necessity of addressing both the experiences of illness and the broader socio-economic dynamics. An aspect of their perspective is part of a broader movement which sees all knowledge relating to the body, health and illness is a cultural product which is constantly undergoing negotiation (Lock and Gordon 1988; Mulkay 1979; Toulmin 1982). Integral to their approach is that biomedicine can now be seen as a subject of medical anthropological analysis as a product of particular historical and cultural processes. As the authors assert, critically interpretive medical anthropologists are “confronted with rebellious and ‘anarchic’ bodies- bodies that refuse to conform (or submit) to presumably universal categories and concepts of diseases, distress and medical efficacy” (Lock and Scheper-Hughes 1986:43). And this is precisely what we are faced with in our study- individuals who resist the labels and interpretations that has been applied to their illness. Here we are more interested in understanding social life as a “negotiation of meanings” (Marcus and Fisher 1986:26).

In such an approach, anthropologists retain a constructively critical stance, acknowledging the efficacy of biomedicine when appropriate whilst at the same time being critical of the cultural values and traditions under study. Wherever inequalities and hierarchies are “institutionalized, they will of necessity be imposed by means of a dominant cultural ideology, which is likely to inflict a negative self-image, distress, and often ill health on the underprivileged and disenfranchised” (Lock and Scheper-Hughes 1986:44). Of interest to our project is the focus within this approach on regulation and control of individual and social bodies which can be seen as being influenced by the work of Foucault (1973, 1975, 1979, 1980). Foucault (1980) reveals the role psychiatry in producing new forms of power-knowledge over bodies. The proliferation of disease categories and “labels in medicine and psychiatry, resulting in ever more restricted definition of the normal, has created a sick and deviant majority” (Lock and Scheper-Hughes 1986:63). This can be seen as all the more relevant when we look at ethnic minorities in Britain. It would appear that medicine and psychiatry have been allowed to assume a hegemonic role of shaping and responding to human distress (Lock and Scheper-Hughes 1986). The authors suggest that illness can be seen as a form of protest, a reaction to what the individual may see as unacceptable. The medical gaze is, then, “a controlling gaze, through which active (although furtive) forms of protest are transformed into passive acts of breakdown” (Lock and Scheper-Hughes 1986:67).
The recent resurgence of anthropological interest in culture and experience (Good 1994; Kleinman and Kleinman 1995) provides a framework for an examination of the experiential question of how conflict is 'lived' by those caught in its throes (Jenkins and Valiente 1996; Nordstrom and Martin 1992, 1993; Warren 1993). Medical anthropologists have begun to pay closer attention to conflict and also to how everyday forms of violence and suffering (Das 1996; Farmer 1996; Kleinman 1996; Scheper-Hughes 1992, 1996) structure people’s everyday reality and social relations. Many of the most recent works on this subject focus on the mundane and the everyday, on what Henri Lefebvre (1991) has called the ‘revolution of everyday life’. Much has been written on the cultural construction of reality: that being human entails more than anything else creating the cultural worlds we live in and endowing them with significance.

One must also be aware of the construction of discourses of suffering. Mary-Jo DelVecchio Good and colleagues have called attention to the “role of the state and other political, religious, and economic institutions in legitimising, organising, and promoting particular discourses on emotion” (1988: 4). In this way one can investigate the official discourse and the way in which it is related to how it is received or resisted by the person subjected to it. Related to this investigation is the relation between such official discourse conceived as a kind of “symbolic violence” (Bourdieu 1977). As Jenkins (1998) suggests, “these must be addressed by taking into account both public, culture narratives…and personal narratives that may be at the same time constructed by, articulated against, or juxtaposed to them” (126).

The Kleinmans (1996) and Kleinman and Desjarlais (1995) question the process by which individuals pass from their status as suffering through the stage of victim and only to appear on the other end as patient. Increasingly, these complicated stories of suffering, based on real events, “yet reduced to core cultural images of victimisation (post-modern hallmark), are used by health professionals to rewrite social experience in medical terms” (Kleinman and Kleinman 1996:10). As Fernando et al. (1998) suggest, a vicious circle is created “whereby seemingly ‘medical’ solutions are offered for social ills and social issues get medicalised even more” (p.219). Similarly, in their study of mental illness among immigrants in the U.K., Littlewood and Lipsedge (1989) suggest that psychiatry can sometimes be used as a form of social control, misinterpreting the religious and other behaviour of some Afro-Caribbean patients, in addition to their response to discrimination, as evidence of schizophrenia. The authors warn against psychiatry’s role in ‘disguising disadvantage as disease’. As Kim Hopper (1982) has suggested, health professionals are predisposed to “fail to see the secret indignation of the sick”.

The New Cross Cultural Psychiatry

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3 The authors here are discussing political refugees, but such an argument can equally be seen as referring to ethnic minorities and mental illness.
Cross-cultural studies on psychiatric disorders had previously focused on discovering universals while setting aside differences. In a 1977 paper, Kleinman addressed this issue, and by doing so presented a new framework for investigating disorders. The “New Cross Cultural Psychiatry” is a response to the weaknesses of the old approach which ignored cultural influences on illness. Culture always influences illness; we live in a “symbolic world in which social structure extends into the interiority of the person’s body-mind and physiological processes resonate systematically with relationship” (Kleinman, 1987a:49).

The “Old Transcultural Psychiatry” systematically undercut cultural differences in illness in an attempt to find international reliability of psychiatric disorders. Culture in the old transcultural psychiatry is seen as superfluous, a mask obscuring the true underlying processes. Kleinman perceives the main weakness of the old approach is its preoccupation with imposing Western cultural categories as if they were free of cultural influences. Thus, in our project we must see that British psychiatric categories are not culture free, they derive from and are embedded within Western (predominantly European, white, male, middle class) notions of disease and illness. It follows that the tools of psychiatry, such as DSM-IV and its predecessors are just as embedded in meaning and value orientations of the culture in which it was developed- American. Kleinman (1977) suggests that the dominant explanatory model of comparative psychiatry has been that of ‘real’ biological disease surrounded by a series of cultural encrustations.

The most recent theoretical advance affecting the field of cultural psychiatry has been the rethinking in anthropology of the concept of culture. Post modernism has influenced anthropology’s move away from the notion of culture as a set of value orientations and beliefs that are shared across whole populations. Such a definition of culture emphasised both the voluntary and the cognitive aspects of culture (Lewis-Fernandez and Kleinman 1995). As Lewis-Fernandez and Kleinman note, the emphasis on belief as the predominant cross-cultural category “obscured the markedly positivistic slant given to the concept of science” (1995:434). Thus, belief gained the connotation of falsehood, whilst science was seen as synonymous with ahistorical reality. In the past, the main pursuit of the discipline was to catalogue the mental health ‘beliefs’ of non-Western societies, instead of turning a critical eye to the cultural assumptions behind Western scientific psychiatry.

To some, as Littlewood (1999) asserts, this new emphasis on analysing the culture of psychiatry was welcome, but ignored crucial aspects of its subject. Instead of examining the interaction between the psychiatrist and patient, it left the latter as a “mere cipher, a palimpsest on which psychiatric institutions simply inscribed their power” (Littlewood 1999:13). Littlewood further asserts that the possibility that psychopathology in Black people could be better understood, in part, as ‘resistance’- an “active, howbeit unsuccessful, appropriation of the dominant symbolic system for personal ends” (p13) was dismissed as
romanticism or exoticism (Burke 1984; Mercer 1986). The 1990s have demonstrated a slight return to the idea of ‘culture’ in response to the earlier discrediting of the concept. This move away from a concept of culture as perceived attributes of individuals, rather than an “interactive matrix in which different forms of power, representation, ideology and social action clashed, compromised or coalesced (Littlewood and Lipsedge 1982/1997)” (Littlewood 1999:13). In the 1990s the move back toward the idea of culture was a result of objections that the critique of racism allowed little space to individuals strategies of resistance. Another point which spurred on the re-thinking of culture was that an emphasis on “Black” groups emphasised similarities and ignored subtle differences. The emphasis of a “Black culture” disregarded the fact that there are cultural differences within the group and a shared label may not be relevant. It is worthy to be reminded here that one does not need to feel part of an ethnic group to be defined as belonging to it (Dalal 1993).

Cross-cultural psychiatric research has polarized into two schools of thought: the etic approach which advocates the universality of mental illness, while the emic approach argues that mental illness categories need to be generated from within culture (Littlewood 1990). Helman (1985) uses the term ‘biological approach’ for the former, saying it is characterised by the belief that Western psychiatric categories can be applied across cultures as it has a universal biological basis. This approach can be illustrated by Kiev’s (1972) work which asserts that whilst the content of disorders may differ due to culture, the form of psychiatric disorders remains essentially constant throughout the world. Patel et al. (1995) suggest that both approaches have their limitations; “etic studies could lack cultural validity, whereas emic studies may lack compatibility” (1192). For the development of the new cross cultural psychiatry it is increasingly accepted that both etic and emic approaches need to be integrated (Leff 1990). As Littlewood (1998) asserts, transcultural psychiatry must move beyond a mere translation of emic/etic categories and examine their interrelations more carefully. We would suggest that in our project one of the main causes of conflict is a disagreement between emic and etic perspectives where the etic perspective has the power. Thus, part of our endeavour will be to examine the interrelations of these two perspectives of patient and clinician.

Littlewood (1999) points out that in the 1980s there was a shift within transcultural psychiatry from emphasising culture to emphasising racism. The shift came from an attempt to situate the practice of psychiatry within a social field. Yet, the “non-medical explanations which were offered remained simplistic, at times conspiratorial, but still individualistic rather than political” (Littlewood 1999:12). The focus was now on the psychiatrist’s experiences, attitudes and actions and how they related to the clinical encounter. The author goes on to note that the relativity of psychiatric categories appeared to be illustrated when a well-publicised study in Birmingham on the medical conception of the term
‘cannabis psychosis’\textsuperscript{4} was accompanied by its virtual disappearance within two years (Littlewood 1999). Finally, Littlewood (1998) suggests, the present perspective of cross cultural psychiatry is “not useful solely in relation to ethnic and cultural minorities (but see Oakley 1975). It is relevant to the description of emotional experience in different classes, between the sexes, or in situations of social mobility or cultural change” (p.17).

**Anthropological Understandings of Schizophrenia: Notions of Self**

From the approaches within medical anthropology and the New Cross Cultural Psychiatry (as described above) there emerges the need to maintain the ‘thick dimension of experience’. Many of the patients involved in this project were diagnosed with schizophrenia and understanding their rationale behind their illness became a fundamental part of the project. Schizophrenia can be “conceived as affecting the person’s total experience of him/herself and of the world, as most illnesses do, but more so than other disorders since schizophrenia strikes at the very heart of what is considered the essence of the person (Carpenter 1987; Fabrega 1989)” (Corin 1996:5). Schizophrenia is not a stagnant and detached entity, it involves the individual in reactions through time and space with the person transforming the illness is of primary importance to its evolution (Ciompi 1984).

At the core of the self is a system of beliefs and symbol systems which are derived over time and largely influenced by culture. This involves the way we give meaning to our experiences, the way and what we choose to remember and forget. As Estroff suggests, this is the core of who we are and it endures through “evolving clusters of meaning, experience, and knowledge” (Estroff 1989:192). A notion of self evolves out of our experience alone, with others, and with the world at large. Here Estroff is referring to the “meaning-making, worldly-knowing, experience- having self that forms part of the core of each of us. For the person with schizophrenia, this part of the self is thought to be perhaps the most altered, most vulnerable, most hidden or obscured” (Estroff 1989:192).

The emerging themes of schizophrenia which remain somewhat constant and provide the basis for identifying schizophrenia have one thing in common. This commonality rests on the fact that schizophrenia involves the core of the person, his/her relationship with others, and to the world at large. A new trend of research exemplified by Strauss and Estroff emphasizes the subjective aspect of schizophrenia, calling for the need to “correct, compensate or reverse the evolution of the dominant psychiatric paradigm” (Corin 1996:1). According to this new approach to schizophrenia, there is something lacking in a field of mental illness that does not pay close attention to the patient’s subjective experience and sense of self (Strauss and Estroff 1989). Psychiatry is driven to be scientific

\textsuperscript{4} This diagnosis was 95 times more frequent among young Afro-Caribbean men than among a comparable group of white men (Littlewood 1999).
in a narrow sense and by implication psychiatrists often neglect many aspects of the patient’s reports.

The patient is the only mediator available to explain how the illness is experienced. There is a need to listen carefully to the patient’s accounts and to create tools and procedures for doing so. As Strauss and Estroff describe, we can never hear the voices the patient hears we can only listen carefully to their description of it. Logical and meaningful connections within the psychotic experience may be present, but it is only possible to realize this if the correct questions are posed to the individual directly. Notions of self are largely ignored in contemporary psychiatry, which is highly problematic especially with illness such as schizophrenia which attacks and manifests itself in the self. Strauss and Estroff remind us of the importance to recall that the “concept of the ‘self’ has been central to the understanding of psychoses in the work of such pioneers as Kraepelin and Bleuer” (1989:177).

Estroff calls for the need to bring a person back to the centre, and by so doing focus on the notion of the self in relation to schizophrenia. Each person is composed of a series of layers: inner/outer; secret/shared; subjective/objective; individual/social, which remain separate yet overlap with one another (Estroff 1989). Schizophrenia can be characterized as an absence of this overlap, making the individual feel alienated and estranged from themselves and the world. Whereas the self can be seen as a narrative, with a certain continuity through time, schizophrenia takes away that reflexivity; in essence, altering the self. As Estroff posits, this disease involves a struggle for the self and, thus, the self must be brought to the forefront of research.

In an article in the Schizophrenia Bulletin, Strauss emphasises the necessity of seeing the individual as an actor, not merely someone who is controlled by his/her disease. The individual’s subjective experience is the focus of this approach, especially the “interaction between the person and the disorder over time” (Strauss 1989:179). Schizophrenia is a process which is acted upon, interpreted, and altered by the individual experiencing it. Instead of seeing the disorder as an immovable, monolithic force, Strauss creates a model in which the disease and the individual interact and mold on another.

Thus the individual is to be seen as an action-oriented being whose experiences, attitudes, and interpretations have great effect on their illness (Strauss 1989). The recognition of the interdependence of attitude toward illness and the illness itself is necessary for methods of therapy. The new trend suggests that regulatory mechanisms are present in the interaction between disease and patient. Strauss notes that as suggested by Bleuler, Freud, and others, “symptoms themselves may reflect unconscious or conscious efforts at adjustments to provide the person with what is needed to survive” (Strauss 1989:184) People with the illness are perceived in this approach as seeking out and finding ways to cope with and adjust to the disorder.
In some cultures psychoses is seen as caused by external, supernatural forces - are considered to have culturally relevant content, and the individual is thus not rejected from the group. Group participation in healing techniques characterizes the non-industrial world, having the effect of reintegrating the individual into society while simultaneously strengthening group solidarity. Extended families can create a situation in which responsibility and emotional over-involvement are diffused over a broad grouping of people.

We are then left to ask how the work of culture informs the experience of schizophrenia. Culture contributes to the experience of schizophrenia through the meaning systems it provides and through the influence culture has on social reactions (Corin 1994:12). Allowing the individual to articulate their experience of schizophrenia in a meaningful way depends largely on the symbol system and 'myth models' provided by culture. We can hypothesize that the evolution of the disorder “partly reflects the way psychotic experience is integrated within the self, and that this integration is influenced by broad cultural conceptions and attitudes” (Corin 1994:7).

The New Cross Cultural Psychiatry approach has revealed the important impact culture has on illness; but because schizophrenia also alters the core of the person, we must also look at how culture informs the very notion of the self. Culture orders and organizes the way individuals conceptualize themselves and the world; culture informs the very essence of the self. Understanding of oneself does not grow from an “‘inner’ essence relatively independent of the social world, but from experience in a world of meanings, images, and social bonds” (Rosaldo 1984:139). This is central to an anthropological argument for a cultural, relativistic view of the person and self is “the notion that categories of the person are tradition-bound and hence vicariously presented to an individual…Different societies with different social traditions, institutions and practices will thus provide individuals with different categorizations of the person and self” (Fabrega 1989a: 54).

**Cultural Competency for Mental Health Professionals**

Much of the medical discussion around culture approaches the subject from a position of ‘educating’ the patient. Papers, such as that found in the Journal of American Medicine by L. Pachter (1994) have the positive intention of drawing clinicians attention to the important issue of the need for cultural awareness in practice. However, the main theme of such works is that whilst clinicians need to be sensitive to patient’s beliefs and cultural affects, they must try to simultaneously try to educate the patient on the merit of biomedicine. Thus, the clinician “should not attempt to dissuade the patient from these beliefs, but instead to educate him or her as to the importance of biomedical therapy in addition to the patient-held beliefs” (Pachter 1994:693).
The notion of cultural competency first made a serious appearance in relation to health professionals in the 1980s in a paper by Sue et al. (1982). A new approach to service delivery, often referred as cultural competence, came about as a result of widespread awareness of treatment inadequacies for minorities. In light of this awareness, advocates, policymakers and practitioners began to press for a new approach to treatment. The cultural competent approach “has been promoted largely on the basis of humanistic values and intuitive sensibility rather than empirical evidence” (Department of Health and Human Services, USA 2001:36). Cultural competence emphasises the recognition of clients’ cultures and then develops a set of skills, knowledge, and policies to deliver effective treatments (Sue and Sue 1999). Underlying such an approach is the “conviction that services tailored to culture would be more inviting, would encourage minorities to get treatment, and would improve their outcome once in treatment” (Department of Health and Human Services 2001:36). As Sue et al. (1998) suggests, the approach of cultural competence represents a shift in ethnic and race relations in that it places responsibility on mental health services organizations and practitioners and challenges them to deliver culturally appropriate services. In light of the Macpherson Report, it is important to note that one of the main themes of cultural competence is that it makes “treatment effectiveness for a culturally diverse clientele the responsibility of the system, not of the people seeking treatment…[Cultural competence] is a broad-based approach to transform the organization and delivery of all mental health services to meet the diverse needs of all patients” (Department of Human Services 2001:36).

As Fitzgerald (1992) has asserted, building cultural competency among health professionals involves more than just developing an awareness that culture is an issue in health, illness and health care. It is about developing the ability to recognise that others may view the world through different cultural lenses and about identifying and challenging one’s cultural assumptions, values and beliefs. Fitzgerald’s approach deals primarily with culture general competency which treats all health professional interactions as cultural, or even multicultural (Fitzgerald 1992). In culture general competency the “principles, knowledge, skills, etc. associated with intercultural competency are treated as applicable to all interactions, whether or not there are obvious cultural differences” (Fitzgerald :187). This approach mirrors Littlewood’s (1998) suggestion that the new perspective of cross-cultural psychiatry can be applied not only to ethnic and cultural minorities, but also to the description of emotional experience in all situations.

Culture general competency is “about the ability to function in the ambiguous, dynamic, open-ended interactions common to therapy situations for which no adequate cultural blueprint exists; and do so with a reasonable level of comfort” (Fitzgerald, 1992:187). This approach is an attempt to achieve something more in line with Geertz’s (1973) ‘thick description’; an understanding of the content and context at both the micro and macro level and use it as the basis of action.
It may be helpful to view the interactions we are investigating as critical incidents (Brislin et al. 1986; Brislin and Yoshida 1994) in that they are “distinct occurrences or events which involve two or more people; they are neither inherently negative nor positive” (Fitzgerald :190). Critical incidents are ‘social dramas’ (Turner 1974) and like Turner, Sue and Sue (1990: 245) suggest critical incidents represent “an area of conflict of cultures, values, standards, or goals”, but they do not necessarily arise out of conflict situations. In the counseling situation, and similarly in the type of situations upon which we will be focusing, the conflict is one of “disconfirmed expectancies” (Brislin et al. 1986; Fitzgerald et al. 1997; Mullavey-O’Byrne 1994). The interaction or social drama did not play out in the expected way. The critical incidents approach is based upon the idea that we communicate and try to give meaning to distinctive events through narratives and stories. The plot lines, “core metaphors, and rhetorical devices that structure…narrative are drawn from cultural and personal models for arranging in meaningful ways and for effectively communicating those meanings” (Kleinman 1988:49). Narratives can also help to shape and create experience (Kleinman 1988).

The Use of Explanatory Models (EMs)

As mentioned previously, all too often the term insight has been used as shorthand for the degree of congruence between explanatory models of the clinician and patient. Similarly, we have discussed that one of the most common sources of difficulty in reaching a consensus between clinician and patient is incompatibility between the explanatory models at work. Thus, a discussion of explanatory models is integral to our project.

Explanatory models are the “notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process, whether patient or clinician” (Kleinman 1980:105). Explanatory models were initially represented as a clinical and research tool for documenting individual interpretations of illness. However, contemporary frameworks “have been elaborated to incorporate individual explanations of illness with the recognition that clients and clinicians share a common body of meanings with members of their subcultural group” (Kaufert 1990:212). Good and Good (1981) emphasize that explanatory models draw on belief systems of the culture at large. Individual interpretations of illness and treatment is influenced by the wider contextual web of shared meanings, referred to as semantic illness networks (Good and Good 1981). Explanatory models are embedded in larger cognitive systems, which are derived from and constructed by cultural and social structural arrangements. EMs emphasise the differentiation of etic and emic perspectives of illness (Littlewood 1990).

Of central importance to health care and our project is the way in which the explanatory models of the patient and practitioner interact. The study of this
interaction offers a more precise analysis of the problems in clinical communication (Kleinman 1980). Some of the initial formulations in the ethnomedical literature dealt insufficiently with the process through which explanatory models are elicited and modified within context of social interactions. We must acknowledge that explanatory models are not hermeneutically sealed, they are constantly undergoing alteration. More recent formulations by Katon and Kleinman (1981) recognize that explanatory models are negotiated and individual interpretations are modified through interaction with the models of other participants. Thus, our project will be interested in the interaction between client and clinician and how the models may be modified throughout the study.

By looking at explanatory models\(^5\) held by patients and their families, we can see the way in which the individuals make sense of given episodes of illness and how they choose and evaluate treatments and therapists (Kleinman 1980). EMs also are involved in the process by which an individual and those around them cast personal and social meaning on the experience of illness. We must distinguish explanatory models from general beliefs, however. Although they draw from belief systems, explanatory models are in response to a particular illness episode (Kleinman 1980) and, thus, must be analyzed in context.

Patient and family explanatory models are not singular, possessing single referents. Instead, they represent semantic networks that loosely link a variety of concepts and experiences (Good 1977). Explanatory models mix together concepts from very different sources. Lay explanatory models are characterised by “vagueness, multiplicity of meanings, frequent changes, and lack of sharp boundaries between ideas and experiences” (Kleinman 1980: 107). The metaphors, idioms and logics that are employed by lay EMs are substantially different from those of scientific medicine. Ethnicity, social class and education influence choice of metaphor and idiom (Apple 1960; Campbell 1975; Elder 1973; Mabry 1964).

Patients’ beliefs related to their illness can be elicited by direct questioning. In clinical settings\(^6\) it is useful to ask general, open-ended questions; but if these questions do not draw significant information, a number of more directed questions may be helpful. These questions enquire about the nature of the problem, its cause, its consequences and the expectation of the individual (Kleinman 1980, see p.106). Patients are often reluctant to share their models with practitioners for fear of being labeled as uneducated. Thus, it will be pertinent for our project that the mediator is not a clinician, allowing for a dynamic where the patient will feel more comfortable to share their views.

\(^5\) Kleinman distinguished five major questions that EMs seek to explain: 1) etiology; 2) time and mode of onset symptoms; 3) pathophysiology; 4) course of sickness; and 5) treatment. Practitioner models tend to answer most or all of these concerns, whereas patient and family models “address what are regarded as the most salient concerns” (Kleinman 1980:106).

\(^6\) Kleinman suggests that explanatory models are more easily elicited in a patient’s home by a researcher not involved in delivery of health care to the patient.
Weiss et al. (1995) suggests, “if from the outset diagnostic systems and hierarchies had been based on clinical experience with a different set of patients…and if the significance of patients’ perceptions and experiences had been acknowledged, we might then expect that current nosologies would emphasise somatoform, rather than depressive disorders” (358). Personal meanings and other aspects of phenomenological and subjective experience should be incorporated into psychiatric evaluations and practice. Not only would the inclusion help in individual therapy, it would also “contribute a measure of face validity that complements standard epidemiological criteria for validity” (Weiss et al., 1995:358). Subjective experience incorporated into psychiatric evaluation and practice provides a more powerful framework for addressing questions of cultural validity in multicultural clinical settings and for international comparisons (Weiss et al., 1995). Here we see a situation in which the emic informs the etic perspective.

The Explanatory Model Interview (EMI) was designed to elicit information about illness beliefs as part of a study on explanatory models in Harare, Zimbabwe (V. Patel et al. 1995). It is a semi-structured interview and incorporates both qualitative and quantitative items. The main structure of the interview is based on the above-mentioned questions developed by Kleinman (1980). In the study the EMI provides the emic framework to balance with the etic methods— the Revised Clinical Interview Schedule. The Short Explanatory Model Interview (SEMI) (Loyd and St. Louis 1993; K. Lloyd et al. 1998) was further developed as a response to the tools available which were seen as too cumbersome to benefit large-scale fieldwork. The instruments available to elicit explanatory models before its development (Becker 1974; Eisenbruch 1990; Weiss et al. 1986, 1992) were detailed and thus time consuming. This tool is designed to be simple for use in routine clinical practice and research and is not intended to replace anthropological methods of study. However, very nature of explanatory models does not lend itself well to quick analysis, easy translation and simple comparisons; and we must, then, question the validity of such a tool. We would suggest that such a tool may not lend itself to the nature of our endeavour.

Our project also intends to elicit the explanatory model of the clinician for that particular patient’s illness. Practitioner explanatory models tell us something about how practitioners understand and treat sickness. Gaine’s research on psychiatrists has shown that clinician’s explanatory models are also based on the cultural assumptions of biomedicine and are influenced by the physician’s professional socialization and subsequent clinical encounters (Gaines 1985). Often models employed by the practitioner are not often transmitted fully to the patient, causing a further breakdown in communication. Explanatory models of practitioners are more accessible to the researcher, but often they differ in the ways they are transmitted to the patient, thus, it is possible to divide them into ‘theoretical and clinical types (Kleinman 1980). Research into practitioners’ EMs must not rely upon what the clinician tells them, but also through observation of how they transmit their EMs to the patient.
Both practitioner EMs and popular EMs are tacit; they are products of circumstances and impressionistic assessments. They are “plastic enough to cover a wide range of experiences and imprecise enough not to be refuted by scientific happenings” (Kleinman 1980:109). As Kleinman (1980) contends, the fact that the two draw on the same popular rationality contributes significantly to the therapeutic process. Notably, explanatory models employed by clinicians frequently “diverge considerably from biomedical and other ‘professional’ theories if they are to be practically effective” (Kleinman 1980: 110).

The therapeutic process inevitably involves a dialogue, however imbalanced, between the two explanatory models. The patient’s explanatory model will be affected and shaped by the clinical encounter just as the practitioner’s model will be affected by that of the patient. However, in general, explanatory models are not shared nor negotiated in the clinical setting; often they conflict and have negative therapeutic consequences. The doctor’s EM may be so different from the patient’s that the patient will misinterpret it. The doctor “almost certainly will fail to treat problems that are part of the patient’s EM, but not the medical EM” (Kleinman 1980:116). This will likely result in the patient rejecting treatment. Indeed, patient satisfaction in relation to treatment is bound to shared and negotiated explanatory models. As Callan and Littlewood (1998) illustrate, the most significant association with satisfaction was concordance between the patient’s and the psychiatrist’s explanatory model. These findings have particular relevance to our investigation which takes as its starting point a patient’s dissatisfaction with their treatment and/or diagnosis. The elicitation of the patient’s EMs aid the physician to understand the patient and help the patient make sense of their experience (Lloyd et al. 1998). The set of questions used to elicit an explanatory model and the idea that it constitutes important data are easy to transmit to practitioners as the questions strongly resemble questions used in normal primary care encounters and those who developed them are practitioners themselves (Chrisman and Johnson 1986).

Despite the strong appeal of the explanatory model framework, ethnomedical approaches have been criticized in terms of their limited capacity to relate client and clinician beliefs to actual interaction patterns (Young 1982). These critiques of the early models have been formulated by medical anthropologists emphasizing both critical theory (Young 1982; Taussig 1980) or deconstructionist approaches (Scheper-Hughes and Lock 1987). The approach of critical theory “suggests that interpretations of events by participants and the meanings they assign to those events are structured by their historical participation in the social hierarchy” (Kaufert 1990). Proponents of critical theory point out that clients and health workers have little opportunity to participate in construction of cultural ideologies which help to construct their explanatory models. Explanatory models are a product of historical and ideological relations of economic and social inequality. People are not able to pick and choose their beliefs and values.
Thus, critical theorists would introduce the perspective of political economy into the equation, as mentioned previously.

**Religion**

(For an excellent discussion about the role of religion in the Mental Health Services, see Fallott 1993).

It soon became clear that one of the main themes which emerged from this project arose out of the issue of religion and spirituality. As it was a theme which seemed to emerge repeatedly, I [Susie Kilshaw] began to do additional research on the subject of religion and its relationship to psychiatry. The following section is a result of this research. It is important to note, however, that this section was added at a later date as I did not realise what an important role religion would play in the project. The discussion about religion can be seen as linked with the above concern with the lack of seeing people in context, in addition to other themes such as discrimination and racism. Religion and spirituality are often a major part of a person's context and effect the way they experience and think about their world and their experiences. The religious and spiritual dimensions of culture are among the most important factors that structure human experience, beliefs, values and behaviour, and illness patterns (Browning *et al.* 1990; James 1961; Krippner and Welch 1992). Yet psychiatry, “in its diagnostic classification systems as well as its theory, research, and practice, has tended to either ignore or pathologize the religious and spiritual dimensions of life” (Lukoff *et al.* 1992:673).

Religion and psychiatry have also been viewed as competing belief systems for giving meaning to the world (Lovinger 1985). As mental health practice became increasingly allied with natural science and rationalistic paradigms in the early twentieth century, many psychiatrists and psychologists wrote dismissively of spiritual or religious experience. Conversely, some religious people have adamantly denied the value of secular mental health services and rely solely on religious sources of help for mental disorders and problems in living.

The historical antagonism between the biobehavioural sciences and religion has led to certain psychodynamic and cognitive-rational traditions seeing religion as closely tied to maladaptive defensive functions, to irrational and distorted views of reality, or to automatically rigid and dogmatic patterns of thinking (Fallott 1998). On such theoretical grounds, some mental health professionals interpret religious experience as inherently regressive, primitive, or disfunctional. Such concerns “are often heightened in working with people who have severe mental illnesses and for who delusions and hallucinations are not uncommon. In these cases, the clinician may have difficulty- both conceptually and clinically- in
distinguishing, for example, between religious delusions and valid commitments” (Fallot 1998:6). The negative view of religion is embedded within psychiatry itself and its diagnostic practices. For instance, in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1987), religion is consistently portrayed negatively. All 12 references to religion in the Glossary of Technical Terms are used to illustrate pathology (Lukoff *et al.* 1992). These references are conspicuous because “with the exception of a single reference to politics, the glossary mentions no other particular area of human experience (Post 1990, 1992).

Neeleman and King’s (1993) study of psychiatrists in London found a wide variation of opinions about the influence of religion on mental health and very few referrals to area clergy. It would seem that little collaboration with religious leaders may reflect negative rather than neutral attitudes about religion and spirituality (King 2001). While Neeleman and King speculated that many psychiatrists view religion as “peripheral”, others have expressed more negative views about religion and health (King 2000). Watters (1992) wrote that “Christian doctrine and teachings, deeply ingrained as they are in Western society, are incompatible with the development and maintenance of sound health, and not only mental health in human beings” (p. 10). He contends that not only is religion irrelevant, but that it is actually harmful to patients, and advocates seeing religious conviction as pathology (King 2001). Viewing religion as harmful does not reflect recent research (Levin 1994; Craigie *et al.* 1990; Levin and Schiller 1987; Mathews *et al.* 1998). Furthermore, a number of studies point to the positive association between religious belief and activity and psychological well-being (Comstock and Partridge 1972; Finney and Malony 1985; Griffeth *et al.* 1986; Martin 1984; Stack 1983) Many people rely on or reach for spiritual/religious faith when crises strike, particularly in times of serious mental illness. Religion as a coping mechanism has been shown to reduce anxiety and to assist in recovery from many types of mental illness and other conditions (Matthew *et al.* 1998; Park *et al.* 1990; Fallot 1998). Lowenthal (1995) suggests that good mental health may go with religiously encouraged social support, religious ideas, feeling, experiences and orientation.

Neeleman and King (1993) surveyed 231 psychiatrists working in London. Only 27% of those surveyed reported a religious affiliation and 23% reported a belief in God. These numbers are in stark contrast to the beliefs of the general population, with up to 80% of the population of Great Britain stating that they believe in God (Argyle and Beit-Hallahmi 1975). These findings reflect the so-called religiosity gap between mental health professionals and the general public (Lukoff, Lu, and Turner 1992). Organized religion and certain religious beliefs apparently play a smaller role in the lives of psychologists and psychiatrists than in other people’s lives.

It is unclear, say Neeleman and King (1993) whether psychiatric training leads to a reduction in personal beliefs or whether psychiatry attracts people with less
personal religious conviction. The researchers found that psychiatrists who were religious were more likely to make referrals to religious leaders. The authors state that psychiatry has remained relatively isolated from research undertaken into religion by other disciplines. Recent surveys of the psychiatric practice (Larson et al. 1986; Larson et al. 1992) literature demonstrated that few studies consider religious variables, “and those that do, lack conceptual and methodological sophistication” (Neeleman and King 1993:420). This is the case despite the fact that it is recognized that assessment of patients' religious attitudes may be important to psychiatric care (American Journal of Psychiatry 1990). No professional consensus in the UK has emerged to guide clinicians in this area. As Neeleman and King (1993) suggest, the absence of guidelines may give rise to idiosyncratic practice among some religious psychiatrists or clinicians with little concept of religion may be dismissive of their patients’ beliefs (American Journal of Psychiatry 1990; Ellis 1980).

The negative view of religion within psychiatry is held in stark contrast to the role it plays in the people for who it is supposed to care. Patients who are admitted to intensive care, facing surgery, or have severe psychiatric illness often have more religious and spiritual concerns (Fitchett et al. 1997; Koenig et al. 1992). One study documented that 80 percent of psychiatric patients had three or more specific religious or spiritual needs that they would like addressed (Fitchett et al. 1997). Yet, despite the importance in people’s lives, religion is often not included in psychiatric history taking. This fact is surprising in that such history taking usually involves covering the most intimate details of a patient’s life. King (2001) suggests that taking a spiritual history should be a feature of the clinical interaction. Such a history would involve the process of gathering information from patients about their values, religious beliefs, belief in God, and whatever gives their life meaning. In the clinical context, such a history taking would also include questioning the individual about how their spiritual views affect their views on illness and health. Fallott, Freeman and Haydon (1997) developed a spiritual assessment method which was developed from Fitchett’s 1993 model. Littlewood and Lipsedge (1998) developed the Religious Interest Questionnaire (RIQ) to collect accessible details of a person’s religious background, practice, belief and experience.

The lack of sensitivity to the cultural forces of religion and spirituality reflects a general and powerful trend in psychiatry that has been discussed above, this being the ontological primacy that psychiatry assigns to biology over culture. The narrow focus on biological factors, combined with the “historical biases against religious and spiritual experiences, impedes culturally sensitive understanding and treatment of psychoreligious and psychospiritual problems. This is particularly apparent when ethnic minorities and non-western societies are considered.” (Lukoff et al. 1992:676). Again, we see the necessity of seeing a person in their context. When the cultural context of the individual is considered, some problems that present with unusual religious or spiritual content are, in fact, found to be free of psychopathology.
Fulford (1996) has suggested that “religion and psychiatry occupy the same country, a landscape of meanings, significance, guilt, belief, values, visions, suffering and healing” (p.5). The closeness of these two disciplines may account for their, sometimes mutual, distrust. The separation between psychiatry and religion is deep-rooted in the history of psychiatry which found the discipline developing a powerful identification with the “medical model” (Macklin 1973). According to this model psychiatry is, essentially a science. Psychiatry, therefore, “in identifying with the medical model, has come to think of itself as a branch of science, and hence, by implication, as separate from religion both epistemologically and ethically” (Fulford 1996:6). The interaction between religion and psychiatry can be at several different levels. Psychiatric patients “may have religious beliefs that may need to be taken into consideration when planning any management. They may also seek help from religion and religious healers, using different models of distress” (Bhugra 1996:3). On another level, the interaction of the psychiatrist’s religious views and the patient’s religious views may cause conflict.

Fallott (1998) suggests, it is important to recognize that for many people with severe mental disorders, religious issues may be cause for distress but are not themselves expressions of mental illness. Lukoff, Lu and Turner (1995) emphasize the importance of understanding the person’s basic religious convictions and that of his or her religious community in order to assess psychopathology adequately.

As mentioned previously, the negative view of religion prevents collaboration with religious leaders who may play a significant role in patient’s lives. Virtually all of the respondents to Neeleman and King’s (1993) questionnaire considered that there were links between religion and mental illness, and the same proportion indicated that psychiatrists should concern themselves with the religious beliefs of their patients during assessment and therapy. The respondents views to Neeleman and King’s (1993) survey varied widely in regards to their associations between religion and mental illness. Of the 213 respondents, 166 (78%) considered that religion was a possible way to sublimate psychological problems, 157 (74%) that mental illness may intensify religious belief, 129 (61%) that religion may protect from mental illness, 109 (52%) that mental illness may reduce religious belief and 90 (42%) that religion may lead to religious ill health. Neeleman and King (1993) also found that religious leaders were not generally considered as agencies to whom direct referral by doctors should be made. Of the 133 (58%) respondents who indicated that they had never made a referral to a religious leader, “70 considered that it was up to the patient to indicate contact, 54 that referral of this nature was inappropriate for psychiatrists to make. Twenty were unfamiliar with suitable religious leaders, 17 had never thought of a referral” (p.422). As Fulford (1996) suggests, there should be a move from tolerant indifference to tolerant engagement as the basis of good practice in both disciplines.
The discussion of religion is even more appropriate given that this study focused on black clients. Research suggests that religion is highly influential to African-Caribbean people, including the importance of religiously encouraged support networks (Loewenthal 1995). The literature indicates a strong association between religion and various measures of physical and mental health. Religion provides social support for the phases of initial onset, prevention of relapse, and recovery. Religion also mitigates the effects of stress in that worship-related activities induce feelings of well being and other beneficial social cognitive factors like identity and self-esteem.

**Patient and Doctor Interactions - Power Relationships/ Satisfaction**

In its attempt to become “recognised as a purely naturalistic science, independent of the particular moral values in which it has developed, Western medicine has played down the social relationship between patient and doctor, and between the experience of suffering and the local understandings though which suffering occurs” (Littlewood 1996:245). The doctor/patient relationship has, in the past three decades, been the focus of significant theoretical work in the fields of medical anthropology and medical sociology (Lazarus 1988; Zola 1985; Waitzkin and Stoeckle 1976). Medical anthropology’s approach to understanding cross-cultural clinician-client relationships has primarily involved attempts to document how doctors’ and patients’ interpretations of illness diverge. Medical anthropologists have predominantly used explanatory models in their quest to analyze patient-doctor interactions.

In contrast to anthropologists’ search for cultural models, medical sociologists have primarily focused on the dynamics of what happens or fails to happen in relations between professionals and clients (Kaufert 1990). Sociologists are mainly concerned with the interaction process, with control mechanisms and with the impact of roles and organizational structure of medical institutions (Bloom 1976). As mentioned previously, both sociologists and anthropologists have begun to examine the impact of broader sociopolitical and economic factors upon the dynamics of power in relationships between clients and caregivers (Lazarus 1988; Waitzkin and Stoeckle 1976). Medical sociologists have used a symbolic interactionist framework to examine the relative power, potential for social control and differential access to information among the participants in client/clinician relationship (Stimson and Webb 1975; Tuckett et al. 1985). This discipline has more explicitly considered the influence of external political structures within the health care delivery system and society (Waitzken and Stoeckle 1976). The asymmetry in patient/doctor relationships has been explained in terms of professional dominance relationships and clinical control over technology (Friedson 1970; Zola 1981).

Evaluation of health care increasingly recognises the need to elicit the views of its users. Government reports over the last decade have recommended that the
health service should be more responsive to consumer opinion. These reports include the NHS Management Inquiry (DHSS, 1983), the White Papers Working for Patients (1988) and the Patients’ Charter (DoH, 1991). The traditional model of medical decision making in which doctors make nearly all decisions on behalf of their patients is a paternalistic one. This model has increasingly viewed as outdated (Royal Pharmaceutical Society of Great Britain 1997). Patients⁷ are demanding more control of the decisions regarding their health and this movement has been responded to by the medical literature. Issues of power and control in the doctor-patient relationship were the focus of the socio-political critiques of medicine which reached their peak in the 1970s⁸ (for examples see Illich 1976; Doyal; Ehrenreich and English 1979). The traditional model is being replaced by more emphasis on the role of the patient in the therapeutic process and an increasing interest in ‘patient-centred’ strategies (Stewart et al. 1995). In the traditional biomedical model the patient’s illness is reduced to a set of signs and symptoms which are investigated and interpreted within a positivist biomedical framework (Mead and Bower 2000).

Echoing the trend throughout disciplines relating to the medical sciences, the new patient-centred approach stresses the importance of understanding patients’ experiences and any relevant social and psychological factors (Stevenson et al. 2000). Mead and Bower (2000) outline five main ways in which the patient-centred approach differs from the biomedical model, one of which involves the development of Engel’s ‘biopsychosocial model’ (Engel 1977, 1980). This model further develops the inclusion of psychological and sociological perspective and sees disorders conceptualised as existing at a number of interacting hierarchical levels, (from biological levels through to psychological and social levels). But, in this approach the psychosocial model is seen as not enough to fully understand a patient’s experience of their illness, which depends on their particular ‘biography’ (Armstrong 1979). Attending to the patient’s narrative of their illness (Smith and Hoppe 1991) involves exploring the presenting symptoms and the broader life setting in which they occur (Lipkin et al. 1985; Stewart et al 1995). The implication is that in order to understand a patient’s illness and to alleviate their suffering, the clinician must first understand the personal meaning of the illness for the patient (Mead and Bower 2000). Thus, the patient is seen as a person and it is understood that the patient is experiencing individual rather that the object of some disease entity and they are seen as an idiosyncratic personality within his or her unique context (Bower 1998).

The patient-centred approach involves “doctors employing active listening skills in order to encourage patients to express their agendas, attempting to understand patients’ points of view and expectations, and working with patients to find common ground regarding management (Stevenson et al. 2000:830). An additional characteristic of patient-centred medicine, as described by Mead and Bower (2000), is the sharing of power and responsibility between the doctor and

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⁷ The patient’s rights movement as been gaining momentum since the 1960s.
⁸ These critiques came particularly from feminist critiques of medical patriarchy in the 1970s.
the patient. In response to the critique of the paternalistic model of medicine, authors in the 1970s and 1980s began to advocate a shift in doctor-patient relations from the "‘co-operation-guidance’ model (analogous to a parent-child relationship) to mutual participation’ (analogous to a relationship between adults)” (Mead and Bower 2000:1090). Shared decision making has a number of similarities with patient-centred medicine, but it includes patient’s active involvement in the treatment decision (Katon and Kleinman 1981; Charles et al. 1997; Coulter 1997). Stevenson et al.’s (2000) investigation into the prevalence of shared decision making discovered that very little is occurring in practice, despite advocacy for its use.

We also know that our “own systems of lay psychology- our personal understanding- are neither fixed nor rigid, for they are contingent on context” (Littlewood, 1990:9). Thus, Littlewood suggests that we must investigate the context of the patient/therapist interaction in some detail, the politics of the therapeutic encounter. Research into the doctor-patient relationship has found that patient satisfaction with care is often related to compliance and clinical outcome (Fitzpatrick 1993). It is generally assumed that black and ethnic minority groups are less satisfied with psychiatric services than are the majority community. It is believed that dissatisfaction of this kind derives from unequal treatment based on covert racism, whether specifically in medicine or in wider frameworks of social structures (Littlewood and Lipsedge 1989). Yet, as Callan and Littlewood (1998) point out, the only currently published systematic study of the time found no difference in satisfaction between British Afro-Caribbean patients and their white counterparts (McGovern and Hemmings 1994). However, despite the lack of research within this area, it can be predicted that satisfaction with mental health services will be low among minority patients (Callan and Littlewood 1998).

Although a professional and hence “contractual relationship entailing formal universalistic features is established, the psychiatrist-patient relationship is also a sharing human relationship, and emotional features linked to its humanistic side invariably come to color it” (Fabrega, 1989c:170). The effectiveness of therapeutic intervention is influenced by the relationship between patient and practitioner (Fox and Storms 1981). This relationship depends, in part, upon shared cultural assumptions about disease and illness (Marsella and White 1982). In ethnomedical research cultural barriers to effective client-clinician communication have been linked with non-compliance, client dissatisfaction and unequal access to care (Kaufert 1990). Medical anthropology’s approach to understanding cross-cultural patient-doctor relationships has primarily focused on documenting how clients’ and clinicians’ interpretations of illness and health diverge. There is unlikely to be a basis of friendship or even an acceptance of help until both the doctor and the patient can agree on common ground (Littlewood and Lipsedge 1989). The authors go on to note that, at present “this tension is resolved only when the patient accepts the doctor’s view of the situation and entirely rejects his own” (p.17).
One of the major problems for a patient from a minority cultural group may be that what the patient presents as a problem and the way in which this problem is presented may not fit easily into the standard (European) text-book classifications that the doctor as been taught so meticulously. As we have mentioned before, these categories are generally taken to be culture free. It has been suggested by Littlewood (1990; Littlewood and Lipsedge 1989/1997), that while people from what are perceived to be ‘other cultures’ are very often slotted into the existing categories of mental illness developed in the West, but the reverse simply does not occur. The patient, therefore, is either shoe-horned in, or pushed even more to the margins as occupying some ‘exotic’ or ‘culture-bound’ category of disorder.

A product of the crisis in social psychology, which occurred in the 1970s and 80s, was a concern with language, communication and discourse (Rose, awaiting publication). This development is of interest to our project in that we are focusing on doctor-patient communication, or, more accurately, miscommunication. Psychiatry, as Rose posits, can be seen as a set of discourses and associated techniques, and the clinical encounters are basically communicative. The author continues to say it is understood (Bernstein 1975) that full communicative competence requires that attention be given to the social context within which the communication takes place. Language “cannot be fully decoded unless its social context is taken into account…and the more distant the social context of one participant from the other- say black patient from white psychiatrist- the more room there is for communication breakdown” (Rose, awaiting publication: 5).

Conflict resolution

Conflict, as I. William Zartman observes, is an inevitable aspect of human interaction. Conflict need not be seen in a negative light. Indeed, conflict is necessary to prevent stagnation, to stimulate interests and curiosity. It is the medium though which problems can be aired and solutions arrived at and is the root of personal and social change (Deutsch 1973). The issue for Deutsch is not how to prevent conflict, but how to make it productive.

There have been many different theoretical approaches to understanding conflict. Theoretical approaches often reflect the academic discipline of the theorists. Psychologists have focuses on intrapersonal conflict; economists have focused on game theory and decision making, economic competition, labour negotiations; sociologists have stressed social, role, status and class conflicts (Deutsch 1991). As a result of so much attention from different disciplinary backgrounds, the field of conflict resolution theory has a fragmented appearance, but one can see some common themes emerging. Firstly, it can be seen that most conflicts are mix-motive conflicts which have both cooperative and competitive interests. Secondly, they can be constructive as well as destructive (Deutsch 1991).
A conflict arises when a person’s attributes, such as beliefs, attitudes, goals, interests, values or ideologies, are incompatible with those of another person or group. To the “extent that they give rise to actions which prevent, obstruct, interfere, injure, diminish or make less effective or less likely any attribute of the other that is valued positively by the other” (Deutsch 1991:30). One or both parties may perceive that the existence of the others’ valued attributes threatens or weakens their own valued attributes. As Deutsch (1991) posits, this may not be objective incompatibility, but what is important is that it is perceived incompatibility. Incompatibilities do not necessarily arise “even from differences in attributes that are truly contradictory unless one of the parties insists that the contradictions must be eliminated (that is, the other must give up his contradicting belief, values, interests, goals and so on), or unless each insists that his own belief, and so on, must be subordinate” (Deutsch 1973: 30).

Individual characteristics of participants in conflict as well as their prior relationship with one another will affect the development and course of the dispute (Deutsch 1973). According to Deutsch (1973) for any conflict under scrutiny it is helpful to know something about the following: 1) the characteristics of the parties in conflict, including their motivations; objectives; and physical, intellectual and social resources for waging or resolving conflict. 2) Their prior relationships to one another, including one’s belief about the other’s view of him. 3) The nature of the issue giving rise to the conflict. 4) The social environment within which the conflict occurs, including the nature of the social norms and institutional forms for regulating conflict. Individuals may find themselves in social environments where there is little tradition of cooperative conflict resolution. 5) The consequences of the conflict to each of the participants and other interested parties.

Social interaction takes “place in a social environment- in a family, a group, a community, a nation, a civilization- that has developed techniques, symbols, categories, rules, and values that are relevant to human interactions. Hence, to understand the events that occur in social interactions one must comprehend the interplay of these events with the broader social context which they occur” (Deutsch 1973:8). There is an ongoing project within the theory of conflict resolution that focuses upon what can be called the ‘cultural question’; this being one of the most important questions facing conflict resolution theory. Avruch and Black (1991) outline three separate, yet often conflated, contexts to which the notion of culture can be applied: cross cultural, intercultural and transcultural. The authors focus on a middle range which neither assumes the uniqueness and non-commensurability of either personal experience of cultural traditions not by going the other way which assumes universality and invariance (Avruch and Black 1991). Such an approach is a call for Geertz’ ‘thick description’ (1973) where one takes into account the richer and richer, more and more layered contexts of cultural meaning.
Avruch and Black (1991) support the ethnographic approach such as that used in Kochman’s (1981) analysis of different negotiating tactics at play between Blacks and Whites in the U.S. Kochman’s point, throughout his work, is that we are dealing with more than a superficial question of etiquette or manners. Instead, we must attend to the overall patterning of affect and how affect, among other things gets tied up with larger constructs of (black or white) personhood and self. Kochman’s analysis reveals that culture matters in every social interaction— even intracultural ones; the sharing of a common language in this situation only served to cover up profound differences in perception, style, and moral evaluations of conflictual behaviours (Avruch and Black 1993).

There is a call for a thicker description of culture in conflict resolution theory in response to the tendency in the field to reify culture and see it as “cookbook, rule-ordered system of etiquette” which is homogeneously found within a group (Avruch and Black 1991:28). The authors suggest that the cross-cultural perspective on conflict and conflict resolution is the most useful approach as it makes fewer a priori assumptions about similarities or differences between cultures than intercultural or transcultural approaches (Avruch and Black 1991).

When parties to a conflict “come from different cultures- when the conflict is ‘intercultural’- one cannot presume that all crucial understandings are shared among them” (Avruch and Black 1993). Thus, the first task of a third-party intervenor in intercultural conflict situations, is to pay serious analytical attention to these cultural dimensions. A cultural analysis of the situation must be undertaken by the third party. An analysis of this kind demands that at a point of unintelligibility and non-comprehension the third party stops and makes them the objects of scrutiny, rather than dismissing them (Avruch and Black 1993).

Unlike the idealized cases used in clinical teaching, examples of culturally-related conflict like those upon which we are focusing this project, adopt a patient-clinician format similar to the case examples utilized in teaching medical ethics or socio-legal aspects of medical practice. Anthropologist of law refer to such examples of conflict as “trouble cases” (Llewellyn and Hoebel 1941). Legal anthropologists argue that more can be learned from situations in which there is tension and disturbance that from those which are routine (Kaufert et al. 1984). Anthropologists look for “trouble cases” in situation in which the participants disagree over what constitutes “legitimate” behaviour. In the medical context, the equivalent situation “arises then clinician and patient disagree over what is appropriate behaviour; for example, when a physician interprets a patient’s behaviour as non-compliant, while the patient regards the regimen prescribed as a set of unreasonable demands” (Kaufert et al. 1984). Situations of conflict between clients and clinicians have been used my ethnomethodologists because they articulate the roles of each participant by revealing rules not visible in “normal” clinical interaction (Stimson and Webb 1975). In their work, Kaufert et al. (1984) found that “trouble case” examples could be used to illustrate both
“explanatory models” of participants in clinical encounters, and their wider socio-political and organizational determinants.

Mediation

The word mediation comes from the Latin *medius, medium*, “in the middle”. Mediation is often regarded as a new process, although it has a long history in many different civilisations and cultures (Brown 1982). In recent years there has been an increase in alternative forms of conflict resolution, particularly in the U.S. due to a rapid increase in civil suits filed in federal courts. In addition to their use in traditional areas- business and family, dispute resolution processes have also been used in other areas, such as doctor-patient disputes. Dispute resolution processes are thriving as well outside the legal system.

Models for mediation can be seen in neighbourhood justice centres or community boards in the US where community volunteers to settle local disputes (Singer 1994). Settlements “reached though negotiation, mediation or arbitration promise faster results than do traditional legal, managerial, or bureaucratic processes- and at a fraction of the cost (Singer 1994:13). People at all levels of dispute gain satisfaction from taking an active role in settling their own conflicts. There is also growing evidence that people who reach agreements themselves are more likely to abide by them than are people who are told what to do (Singer 1994).

This increase in mediation and negotiation raises some concerns, however. Is it possible that mediation, with its emphasis on accommodation and compromise will deter “large-scale structural changes in political and societal institutions…and that it will thus serve the interests of the powerful against the disadvantaged?” (Goldberg *et al.* 1992: 10). Informal dispute settlements do not “serve to equalize the bargaining power between participants…who may have markedly different resources or sophistication. Indeed, serious controversy exists over whether informal settlement is appropriate for parties of significantly unequal power or whether it reinforces their difference and thereby produces unfair results: Singer 1994:14).

Mediation is negotiation carried out with the assistance of a third party. In contrast to the arbitrator or judge, the mediator has no power to impose an outcome on the disputing parties. Mediation in a “general form of uncoerced conciliation” (Marshall 1985: viii) involving three or more participants. One of the characteristics of the mediator is that they have little authority, and, thus, the others must accept, trust and respect them. The impartiality of the mediator is central to the process. This means that the mediator does not have a personal interest in the outcome of the dispute and that the mediator will conduct the process in a balanced way (Parkinson 1997). The mediator must convey that they understand the essence of the problem (Goldberg *et al.* 1992). One of the essential tools of the mediator is empathic listening, for when a party feels
someone is listening to them they are more likely to be candid and open to the other side of the dispute (Goldberg et al. 1992). Indeed, in western countries, mediation is generally seen as a means of ‘empowering’ the parties to work out their own decisions and agreements (Parkinson 1997).

Mediation is so general a form that can prove extremely elastic in use, and can be applicable to almost any conceivable instance of conflict (Marshall 1985). MacFarlane (1997) says that the mediation process can be used in a wide range of conflicts, from family matters to major commercial disputes, which have been traditionally either been adjudicated (by the rich) or unresolved (by the poor). A mediator is there to encourage exchanges of information, to provide new information, and to help parties to understand each others views (Goldberg et al. 1992). The authors further outline the role of the mediator, suggesting that they are to deal with differences in perceptions and interests, encourage flexibility and to focus on the future rather than the past (Goldberg et al. 1992). Importantly for our endeavor, Goldberg et al. (1992) suggest that there is no best way to mediate a dispute. There are no hard and fast rules to mediation, with mediation techniques varying with the parties, the conflict, and the mediation program (for a classic text on the mediation process, see Moore 1996). Very typically, a mediator will conduct people through a “sequence of planned stages that are intended to end in a willing agreement to solve a problem and refrain from conflict” (Marshall 1985:viii).

The inability to reach a settlement may be as much due to emotions as to the facts of the dispute. Impoverished communication, “hostile attitudes, and oversensitivity to differences- typical effects of competition- lead to distorted views that may intensify and perpetuate conflict; other distortions commonly occur in the course of interaction” (Deutsch 1991:43). Errors in perception and thought interfere with communication and this is of central concern to our project. These errors make empathy difficult and impair problem solving. Psychologists have provided an inventory of some common forms of misperception and misjudgement occurring during conflict. These include black-white thinking, including demonizing the other, and a self-serving biases.

Mediation provides a forum where individuals can vent their feelings whilst telling their “stories” (Goldberg et al. 1992). Thus, a forum is provided where individuals can communicate and try to give meaning to distinctive events through narratives and stories in an attempt to arrange experience and imbue meaning in those experiences. Mediation allows a space for individuals to “effectively communicating those meanings” (Kleinman 1988:49) and provides individuals with the confidence that they are being heard and understood. There has been much anthropological work on the subject of the narrative importance of illness (Frank 1995; Kleinman 1986, 1988b; Scarry 1985; Abu-Lughod and Lutz 1990). Anthropological work locates cultural frames within which specific idioms for talking about illness become salient and within which the concept of the self as a unique, bounded entity who is singularly authored is brought into doubt. The
very practice and structure of bio-medicine could be said to follow this ‘pathography’ of the course of natural disease in the way plots and time frames are formed around diagnosis, medical intervention and resolution. In a more indirect way much of the focus on the narrative of experience of illness within anthropology originates in and continues to be motivated by a critique of the sustained tendency of bio-medicine to “reify illness as organic disease” (Taussig 1980:12). Arguing that the idioms and narratives for the expression and definition of illness cannot be seen only as personalised renderings of individual lives, the anthropological perspective argues for an understanding of narrative as collective and culturally constituted.

The mediator thus enables disputing parties to re-approach the conflict with greater objectivity and clear-headedness (Goldberg et al. 1992). They are then “encouraged to disclose information they have not disclosed before, listen to things they have not heard before, open their minds to ideas they have not considered and generate ideas that may not have previously occurred to them” (Goldberg et al. 1992:105). Mediators also communicate selected information back and forth, often translating from negative to positive language and serve as an agent of reality (Singer 1994).

One of the aspect of our project which is necessary to address is our choice of the mediation model although there are power differential to be expected between the two parties. Indeed, the literature on mediation address this issue and suggest that differences in power are to be expected in disputes utilising mediation. The literature merely suggests that mediators must take care when dealing with power differentials to between disputants. The main way to deal with power imbalances, according to the literature, is by the skill and acknowledgment of power differentials (Parkinson 1997). Mediators “do not have power to reshuffle the pack and deal out the cards more fairly, yet mediation also claims to provide fair and balanced outcomes” (Parkinson 1997:223). Although mediators are to be neutral, Ingleby (1986) questions whether complete neutrality is appropriate when one of the parties is more vulnerable. The author warned that “if mediators are to be completely neutral as between the parties, then the existing inequalities will merely be reinforced” (Ingleby 1986:67). We also plan to use various methods in order to partially respond to differences in power. One of these ways is to see knowledge as a source of power and, thus, we must frame knowledge in a specific way. Whereas the doctor holds the knowledge of biomedical knowledge, the patient alone is the source of knowledge of his or her illness. As Parkinson (1997) suggests, the sharing of information by both parties can greatly reduce knowledge imbalance.

Parkinson (1997) asks whether mediation has the dual aim of settling disputes and resolving conflict. Central to this question is the distinction between conflicts and disputes. Disputes are overt and in settling them disputants may negotiate

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*9 Much of the mediation literature on the subject of power inequalities centre around gender differences and power in family mediation.*
terms of settlement which may involve concession or compromise on one or both sides. In mediation there is usually a pragmatic recognition of the need for settlement. The terms of settlement "may be accepted reluctantly, however, and the parties' attitudes towards each other do not necessarily change" (Parkinson 1997:10).

One of the difficulties of our project will be in the assessment of success of the mediation approach. Success is difficult to evaluate in mediation as the appraisal of 'quality' of the process and its outcome are complex and elusive (MacFarlane 1997). We can ask the questions of was the process 'fair'? Was the outcome a 'fair' one, but they will be difficult to evaluate. In relation to mediation these questions are not only “conceptually and methodologically complex, but also fit uneasily within the self-determination ethos of mediation” (MacFarlane 1997:19). In an interest-based dispute resolution process it is difficult to impose external criteria of quality, especially in relation to outcome, on the disputants (Baruch Bush 1989). Whether the outcome was worth the time and effort put into it, or if the result was acceptable and fair, seems to be up to the participants alone.

Other Approaches

Some ethicists have suggested that those situations involving cultural conflict can be mediated by using strategies that allow the patient, family members, and the providers the opportunity to clarify their values (Jennings 1994; Jecker et al. 1995). Others have suggested that consultants with special knowledge of the culture be used to mediate the situations in which conflicts occur (Gostin 1995). As Kaufert et al. (1999) point out, “generally the limited literature on the cultural dimensions of bioethics suggests that the conflicts can be resolved by altering communication styles and using language intermediaries who maintain neutrality and provide technically proficient language translation” (p.32).

Kaufert and his colleagues have studied and developed interpretation services for Native Canadians in Winnipeg hospitals (Kaufert, Putsch and Lavallee 1999; Kaufert 1990; Kaufert and O'Neil 1995). The participation of interpreters began as a result of the need for language translators as many Native Canadians could not speak English. The role of these interpreters was mainly as medical interpreters who would explain medical terminology to Native patients. The interpreters, who were native, were trained to undertake a variety of responsibilities, including interpretation, record keeping, independent visitation of hospitalized patients, limited crisis intervention, and social services work (Kaufert, Putsch and Lavallee 1999). The interpreter are allowed to add relevant cultural information to patient records. Aboriginal services programs in Winnipeg “have been developed to meet an essential need for language services, social support, and cultural mediation on behalf of patients and families from remote communities (Kaufert, Putsch and Lavallee 1999).
Although the programme was developed to respond to translation needs, it became clear to those working with and studying the role realised that Native Canadians interpreters played multiple roles. They acted as a) language translators; b) cultural informants describing Native health practices and community health issues; c) interpreters of biomedical concepts; and d) patient and community advocates. The authors found, however, that interpreters had to develop appropriate metaphors of examples which had personal meaning for the client. Interpreters also played a pivotal brokering function by explaining Cree, Ojibway and Inuit cultural perspectives. The interpreters worked with patients to develop culturally meaningful translations of prognosis and treatment measures. The interpreters often became involved in “mediating the communication of information” and they had a role in conflict resolution (Kaufert, Putsch and Lavallee 1999). The programme in Winnipeg parallel that of bilingual health workers in an interpreter/cultural mediator program developed with the support of the Robert Woods Johnson Foundation in Seattle, Washington (Jackson-Carroll et al. 1998).

Kaufert et al. (1985) found that in contrast to the general lack of recognition of the role of the third party, their research on the work of Cree and Ojibway interpreters in Winnipeg hospitals indicates that intermediaries have a major impact on the clinician/client encounter.

The role of a mediator in the clinical encounter can be seen as not an entirely new concept. Indeed, family members and language interpreters have often acted as intermediaries and translators in cross-cultural clinical encounters. The interpreter can contribute to the reconstruction of shared explanatory models (Kaufert 1990). In eliciting and “summarizing client explanatory models, interpreters can also incorporate explanations which integrate biomedical knowledge and information about sociocultural and economic factors which influence the patient’s response” (Kaufert 1990:215). Observing the work of such interpreters demonstrated the very real problem of mediation between Native and biomedical explanations of death, dying and grieving (Kaufert and O’Neil 1995). In the final analysis “the emphasis upon mediation, interpretation and accommodation of alternate systems of understanding may place interpreter/advocates in a vulnerable position of brokering fundamentally irreconcilable values” (Kaufert and O’Neil 1995:74). I would suggest that this would point to the need for the organizational structure to change instead of putting the weight of finding solutions on the interpreter. Similarly, the role of the Native interpreters is made extremely complicated as they are asked to fulfill a large number of, sometimes conflicting, roles.

In Belgium there is a mediator project which uses health advocates in certain psychiatric hospitals (Hans Verrept, Coordinatiecel Interculturele Bemiddeling, Brussels: personal communication Oct. 19 2000). In this project, members of the cultural group of the patient are used as language and cultural interpreters. This project only works with the Turkish immigrant population in Belgium. Health
advocates facilitate the exchange of correct and detailed information between health staff and patients. The authors also found that patients were less inhibited about telling their stories in the presence of the health advocate. It was also discovered that health advocates were able to resolve a number of conflicts between health staff and Moroccan patients and sometimes successfully defended their clients against insensitive and racist practices.

Such projects differ from our in a number of ways. Most importantly, these approaches involve the use of interpreters/mediators who all share a culture with the clients they serve. The necessity of language interpretation brings this into sharp focus. Such services depend on the interpreter being linguistically and culturally close to the population they serve. As a white Canadian academic I will most likely share little in the way of culture and background with the clients with whom I will work. In our situation we are not working with one cultural group and are not falling into the trap of reducing and reifying culture. Our approach is to apply techniques to gather information to add to clinical encounter and to focus on the individual’s specific understanding of their illness. In our approach language translation is not a key factor as we will only be working with patients who speak English fluently. Although some individuals will suggest that the mediator should be a black person in order to better understand the client’s experiences of racism and discrimination; I would suggest that it would be impossible to find a mediator who could share the culture of all the patients with whom they will work in such a multi-cultural setting. Similarly, as a mediator one would think that the individual would have to share the culture of the patient as well as the culture of psychiatry. It is clear that such an approach would be unworkable. Instead, we decided to use an approach where the mediator could move between the individual and the clinical teams and investigate all the perspectives employed in the clinical encounter.

Another difference is that these approaches result in the interpreters being responsible for a large number of duties and roles which can sometimes be in conflict with one another. Whilst our project separates the advocacy role and the role of a mediator, these projects find the interpreters acting as both. It is integral to this project that the mediator is not seen as an advocate as they are to remain neutral and work between the culture of the patient and the culture of psychiatry. Such approaches are similar to the idea of cultural matching of a therapist with their client. This approach assumes that if client and doctor share a cultural base, conflicts will not arise. Such an approach, however, does not take into account the complexity of culture. It denies the role of socio-economic factors in culture and denies the fact that psychiatry itself is a culture which its participants are encultured into.

Another possible approach to prevent or remedy conflicts within health care services in a multi-cultural setting is a consultation approach. To begin with the “traditional clinical model of care, the task here is to establish what is ‘wrong’ with the patient according to the perspective and expertise of the doctor. I would
argue that this approach, namely ‘A’ recognising what is wrong with ‘B’ according to the conceptual models within which she was trained, is much more central to the essence of the much maligned ‘medical model’ than are any notions of physical causality and treatment (Steinberg 1981; Tyler and Steinberg 1987)” (Steinberg 1992). The consultative model is altogether different. Its requirements are power sharing, ideas sharing, and an exchange of ideas with the consultant. As Steinberg (1992) suggest, rather than blurring the roles of the professional and the patient, this approach clarifies and affirms the position of both.

Conclusions

One of the main themes we can see emerging from this literature review is a shift toward seeing the individual in a more holistic way. Gone are the days when the patient could be seen as an isolated organism silently accepting the decisions of their all-powerful clinician. Instead, the medical sciences are beginning to see that individuals must be seen in context. An individual’s life world, including their culture, and socio-political status, among many others factors will influence every aspect of their illness. Medicine is also acknowledging that a patient’s understanding of and experience of their illness is an important aspect of the clinical encounter. Furthermore, the medical literature is paying heed to the fact that wider societal issues are very much a part of their practice and infiltrate it on many levels.

What we are not seeing emerge out of the literature, however, is clinicians turning a critical eye upon themselves to better understand why they behave as they do. Within medical anthropology there has been a focus upon analysis of biomedicine as a product of particular historical and cultural processes. Thus, we can turn our attentions toward a critical analysis of psychiatry and ask why the discipline and its practitioners behave the way they do. Furthermore, it has been established that medical knowledge is constantly being negotiated and perhaps we can view this project as a negotiation in itself. Whilst anthropologist and sociologist have begun to turn their eye toward such matters, there seems to be little acknowledgment of such literature in the medical papers.

We have also seen that there has been a call from a number of sources within medicine and the social science for a focus on ‘thicker’ descriptions of illness and the way in which individuals experience their illnesses. The issues discussed above, particularly in sections focusing on medical anthropology and cultural psychiatry, has relevance not just to ethnic and cultural minorities, but also has implications for all clinical encounters. As we have seen all encounters can be seen as cultural and affected by one’s experience of class, gender, religion and all other aspects which combine to construct an individual’s identity. It is not the intention to further an approach to psychiatry which treats black and other ethnic minorities on the margins, but instead to offer a possible alleviation to ongoing
suffering whilst attempting to build a model for all clinical encounters which have experienced conflict.

Placing medical anthropology at the centre of the project will develop the process of identifying and understanding the different explanatory models held by the clients and clinicians. Identification and understanding of the explanatory models then becomes the starting point to build a system of interaction where the power dynamics become, or strive to become, equal between the two parties concerned. The literature has shown that misunderstanding is usually documented within psychiatry as the client 'lacking insight' into their illness. For the client to ‘gain insight’ they are encouraged to adopt and conform to the biomedical model presented to them by their clinicians. Thus, this in turn creates an unequal power structure based on the dependency of the client. We argue that the notion of insight cannot be a one sided process but has to be a learning process for both groups resulting in a productive system of communication. The next section examines the different methodologies the project has focused on and how some had to be changed along the way as the project developed.
3. METHODOLOGY

Theoretical Aspects

The main aim of the literature review was to explore the issues we felt would be relevant to this project. A variety of strands were investigated in order to establish themes and approaches which could be tested in the project. We wished to look at the way different disciplines approached these issues and then apply the appropriate techniques and tactics. Throughout the project we continued to research many strands of relevant literature. As themes emerged during work with individual cases, we added components to the literature review to bring in these relevant themes. In addition to an ongoing academic review, we also conducted ongoing research by means of meeting with various groups and individuals who we felt might add helpful advice and direction. We met with user groups, patients, religious leaders, academics, mediators, and other health care professionals.

One main strand emerging from the literature was the discussion surrounding insight as an issue of conflict resolution. It would seem that the doctor presents his position, the patient disagrees, and subsequently the patient is seen as having poor insight because of their illness, their experience, and/or their education. However, we investigated the way in which this situation involved more complicated factors. Different disciplines have different ways of explaining this phenomenon. Anthropology uses explanatory models, whereas other disciplines may point to issues of power relations. The project would look more deeply at the notion of insight and the way it is used in the clinical encounter.

This project set out to use medical anthropological techniques to investigate the issues contained in the interaction between clinician and client. Anthropologists, who immerse themselves in the communities they study in order to gain the in-depth knowledge they require, tend to use unstructured observation as their research method. Such qualitative research is "fundamentally concerned with meaning, understanding and subjective reality" (Stone 1991:449). Qualitative research theory may emerge as the research progresses, that is the study structures the research rather than the other way around, giving rise to the notion of ‘grounded theory’ (Glaser and Strauss 1967). Thus, the study and its methods would develop and change as a result of our interactions and the subsequent findings. Although the project had, from the outset, a clinical focus, it came to take on a different form as a result of the fact that I am an anthropologist. Thus, the focus moved away from conflict resolution and clinical contributions and involved a great deal of observation. Siddell (1993) states: qualitative methods arise from a different philosophical tradition, one which looks for meaning behind social action. This involves more than observing the social world, it requires interaction with the social world. As a researcher one must be part of the process, you need to understand the symbolic nature of social action in the search for meaning.
Psychiatry and the therapy professions have been closely bound with the medical profession and this has shaped the methods used in therapy research in favour of quantification (Stone 1991). Only recently have qualitative research been respected and advocated as a suitable way of investigating these professions. In many ways, however qualitative methods are still denigrated and are seen to not fit into psychiatric research. A wide variety of methods are needed to help us understand the complexities of human behaviour. Quantitative methods are useful, but we also need qualitative methods to understand the why. Thus, in light of the focus on quantitative approaches to looking at such issues, we focused on a more qualitative approach. Qualitative methods are particularly useful at this stage of the investigations into discrimination in the mental health service. This is because the question is no longer about over- or under-representation of Black service users and other ethnic minority groups within psychiatry, but how such communities experience psychiatry. The question is also why such experience is largely negative and discriminatory in nature. Thus, this project will utilise qualitative methods to better assess why this is so.

Medical anthropology has shown us how people resist and rebel attempts at reduction of their problems. Thus, this project was intended to provide a “thicker” level of description and provide more of a contextual approach to the person and their problems. The intention was to gather this thicker description by interviewing the client on a number of occasions whilst also interviewing those around them. Medical anthropology can help to prevent an inappropriate “focus only on the individual and his or symptoms, while ignoring wider familial, social and economic issues” which “may make both consensus and solution to the problem difficult to achieve” (Helman 1994:137). Two of the main sources of difficulty in reaching consensus between clinician and client are the misinterpretation of languages of distress and incompatibility between explanatory models of work. Thus, this project will add to this dimension and investigate whether these are causing conflicts in the clinical setting and whether or not we can remedy such disagreements.

Our main focus was to investigate explanatory models as a way of improving understanding between patient and clinician. The project set out to explore whether it is possible to use mediation as a way to communicate explanatory models and to meet in the middle. Simultaneously the project will look at issues of language to explore whether misunderstandings and disagreement arise out of problems in communication. Misunderstandings in relation to idioms of distress may inform some of our cases. Differences between the etic and the emic perspective will also be investigated. For example, can disagreements be due to the fact that there are these differences, but the etic perspective maintains the power. Issues of racism will also be explored in this project.

Initially it was thought that we would find that there would be two divergent explanatory models at work: the patient’s and their clinician’s (and sometimes the
family's). The project, therefore, was intended to collect the information pertaining to these models and then try to negotiate between them: to build upon common themes and to work with the differences. The goal of the project was to attempt to reach a middle ground between the models, one to which both parties can agree. It will be shown below how such a meeting in the middle was not to be the case.

We did not want the researcher to be confused with a patient advocate, as an advocate is very much there to side with and represent patient. Thus, we decided to use the concept of mediation as it refers to a meeting in the middle where both parties can be satisfied. This factor is particularly relevant for our project, as we aimed to challenge the present frameworks of client/clinician interaction. Our project was not, like many others, an attempt to make the client understand the clinician and their point of view. The role was not to translate the clinicians position and model to the client. Instead, we were trying to resolve conflict through negotiation and increased understanding on the part of both parties. We felt this was a crucial aspect of our approach and the way in which it differed most radically from similar projects. Thus, we needed a technique that could incorporate this as well as clearly implying its approach in its name and title.

We are attempting to resolve conflict and doing so through negotiation with the presence of a third party, as is the definition of mediation. Mediation is voluntary, a necessary component to our project, and the third party is merely there to help the parties come up with their own solution. The mediator is not there to impart a solution or a binding agreement. They are merely there to guide the process and gather information. For mediation to work effectively the mediator must be neutral and impartial. Again, this works well for our endeavor as it is imperative that the parties understand that I am not there for the benefit of only one side. The process and settlements are non-binding. In many ways mediation is a way to increase communication and understanding and, thus, fits neatly into our concepts. Another reason we decided to base our approach on the loose model of mediation is that it is very flexible. We needed a technique which could be easily adapted to our project and also to each individual, their conflict, and their circumstances.

**Applying the Methods**

This section is divided into two main sections which parallel the time line of the project. Part one outlines the methods we chose after the first month of research. These methods arose mainly out of the literature review and an investigation into other projects investigating similar issues. After establishing the methodology the focus was on advertising the service, gaining support for the project, and explaining the approach. Four months into the project we received our first referral. For the first three months of seeing clients we used the methods described in the first section, altering them slightly and testing their
suitability. Seven months into the study it became evident that the interventions were not succeeding in the way we had hoped. Therefore, from the lessons learned in the first stages of the project we developed a new strategy. Although many aspect of the original approach remained, some aspects were altered to create a new approach. We arrived at the new approach through trial and error as we intended to do at the outset of the project. It is this strategy which is outlined in the second part of this section. In the following chapter there will be three cases studies, one from the initial stage where the original methodology was applied and two from the latter stage of the project where the modified strategy was used. These case studies will act as illustrations of the methods used as well as reveal why and in what way we altered the approach.

**Original Methodology**

At the outset of the project we outlined a set of criteria for the clients we would accept into the project. They would:

- be Lambeth clients who have come to The South London and Maudsley NHS Mental Health Trust and diagnosed with first or second episode of a psychotic illness.
- have no other diagnosis- as in severe substance misuse or organic conditions.
- be able to articulate their experience and ideally have a relative to whom we could also speak - this criterion was intended to enable us to validate views and explanations of illness.
- be referred to the mediator as a result of there being a disagreement, either about diagnosis, hospital stay, current or a future treatment and/or about general conceptions of the illness.
- be accessible for a number of interviews over a 3-6 month time frame.

Patient recruitment involved a number of different techniques. All clinicians involved were informed of the project on numerous occasions. The mediator/researcher first approached the clinicians at the Consultant’s Committee meeting on November 8, 2000. The clinicians had been sent an information package about the project before the meeting. Many of the doctors were then approached individually by the mediator/researcher in order to further enforce contact and support. In December further information was sent to the relevant doctors informing them that the project would be accepting patients as of January 2001. At the beginning of January, clinicians were sent an information pack with a letter announcing that the service was ready to start accepting clients. The information pack included: a brief description of the project, the criteria, and the contact details of the mediator; referral forms; and patient information leaflets. Clinicians were asked to inform patients about the service, particularly patients who they thought would benefit from the service. Clinicians were asked to fill out a referral form for each patient they approached about the service whether they accepted the proposition or not. This was in order to gain an understanding of client's interest in the service.
The mediator/researcher also met with the different ward staffs on a number of occasions. She went to ward staff meeting to discuss the project as well as going to community ward meetings to meet with the patients. Each ward was given the information flyer with project details, criteria and contact details. Ward staff were asked to display the flyer in a prominent position to remind staff of the service and to ensure they knew how to contact the mediator. Patient flyers were made available to clients in order that they could contact the mediator directly and self-recruit. This was an important approach in that it was the best way for the mediator to be seen as neutral and not a member of the clinical staff.

When we first established the methodology, we set out to see each patient 5-6 times. We stipulated that all interviews would be taped, if possible. The first meeting was intended to explore the patient’s views about their illness. The first meeting would also involve collecting details about the client including general demographic information, past contact with hospitals, past contact with criminal justice system and nature of the conflict. We felt it would be important to collect contact information for the patient to ensure that they can be reached if they are discharged. The Birchwood et al. (1993) insight scale would be used to assess insight. This scale was chosen because it is brief and can be completed by the patient themselves or with the help of the mediator.

The second meeting would be a chance to confirm that which was discussed in the initial interview and will provide a forum for further exploration. Kleinman’s (1980) questions (see Appendix One) will be used to elicit the patient’s explanatory model for their illness. Kleinman’s questions were chosen as they are flexible and were intended to elicit details of the patient’s understanding of their experiences. Also, these sorts of questions are questions that clinicians should be asking at any rate. What we were trying to do is gather information in a very qualitative way. The intention was to get the patients to talk about their illness in their own words and talk about what are their major concerns and issues. After the initial interviews the mediator would write up a brief report outlining the individual’s case. The mediator would then meet the person’s clinician to explore their explanatory model for this particular client’s present illness experience.

A follow-up interview with the clinician would take place at this point to further explore the issues involved in the case. At this point the mediator would produce a written summary of the findings and possible solutions to the problem. This summary would be presented to the consultant and the mediator and clinician will modify the report if necessary. The summary would then be presented to the patient and they, too, will then have an opportunity to modify the report and suggestions.

The mediator would then have two more meeting with the patient and/or the clinician to attempt to come to a solution. It may also be necessary to embark on
research for an individual case, particularly if the client is constructing their illness in a particularly culturally salient way, i.e. if they are a recent immigrant or have dominant religious beliefs. At this point it was planned that the procedure would cease for a few months. After 3-6 months the patient would be contacted to assess whether or not they feel they benefited from the service. We would then attempt to discover what kind of an impact the experiment had by conducting a satisfaction questionnaire to both the patient and the clinician.

Updated Methodology

As mentioned previously, seven months into the project we began to reassess the approach we had initially chosen. We re-evaluated which aspects were working and which aspects were not, and developed a new strategy. In our experience, the alterations resulted in positive outcomes as will be illustrated below in the case studies. The interventions which occurred during the latter stage of the project resulted in more obvious and dramatic changes, a more positive relationship with the clinicians involved and greater satisfaction from both clients and clinicians. The greatest alteration to our approach was in regards to the use of mediation. Our earlier case studies revealed that it was difficult to find middle ground and to negotiate positions. At the beginning of the project it was thought that as the clinician’s well defined model collided with that of the patient, the mediation approach would be effective in order to negotiate and move between these models. Initially we had thought the process would involve a number of interviews with both parties, presentation of findings after some time without previously giving information, and then negotiation of positions, but we found this process to be both difficult and unhelpful. Instead of mediation, it became clear that a better way to change the outcome would be to change the process. This would mean stepping in much earlier and working alongside the clinical team. Thus, the outcome would be based on better information.

There was great difficulty with regards to the role of the researcher. It became clear that I had two very different roles which were often difficult to combine: a mediator and a researcher. As an anthropologist I am trained as an observer, but I was also being asked to be a mediator- an actor in the clinical process. I was also to be expected, due to the strategy of the project and the expectations of the clinicians, to be an extension of the clinical project. Thus, it was difficult to be independent due to the constraints of the project and the expectations of the clinical teams. There was much difficulty in trying to manage both roles: as a social scientist researching and observing and as a mediator, and not a clinical participant. Instead, my role was to inform the clinical practice only. There was a constant tension between observation and action.

As the year progressed the mediation service evolved and came to take on very different characteristics. It became evident that the mediation model was not working and was not the most appropriate approach. The approach where the researcher would go back and forth between client and clinician did not seem
workable. This was due, in part to the time constraints of the cases and the organisational structure of the hospital. The mediation process which involves in-depth information gathering from both parties and then an ongoing process of moving back and forth with the information whilst adapting and changing suggestions was not appropriate given the crisis situations with which I was dealing. Indeed, the organisational structure made such ongoing mediation between the parties impossible. Mediation often involves one or two days of intense discussions between the parties in question and this simply was not possible in the context of the hospital. Negotiation between clinician's and client's models seemed to work best when the information could be introduced at the early stages of the client-clinician interaction.

In mediation the third party is only there to elicit suggestions from the other parties, I found that this was impossible in this setting. Often it was up to me as the researcher to make suggestions based on the information collected. In many cases the clients would not have had suggestions, in many ways I was working on a level that could not be accessed by mediation. For example, I was often focusing on explanatory models and as has been outlined in the literature review, people often do not know their own explanatory models. Thus, it was not my role to elicit solutions from the clinicians and clients, but to gather information and either make suggestions or merely pass on the information. It was discovered that the service worked better along the lines of an anthropological consultation or cultural interpreter approach. In this way I could find more information to add to the assessment and treatment of the individual.

An interesting point was raised by a counsellor/psychologist who worked at the Greenwich project which provides mental health services for black clients. He suggested that in his experience, mediation in the black tradition is likened to a shaman. He suggested that such a person mediates between two worlds, but to do so the individual must have mastery over both worlds. He suggested that one could draw parallels with my role and its difficulties as I was being asked to mediate between two worlds, but I did not have mastery over either.

There remains the question, therefore, of how does anthropology fit in with the biomedical clinical setting. One of the key elements is to accept the approach of social science. The researcher should not be there merely as a clinical buffer but should be positioned as an independent observer and not as an active participant within the clinical process. The way to prevent this situation from repeating itself is, in part, through proper training and preparing people for the research and the project. Similarly, there needs to be a clearly defined role for the researcher. There is the real need in a project of this kind to separate observation from action in order for the roles not to be confused.

The role of the mediator/researcher in conflict resolution also came under scrutiny. Some would suggest that it should not be an outside researcher who is made responsible for easing conflicts between patient and doctor. It became
clear that the best way forward would be to prevent conflicts and disagreements by a different approach. Indeed, it is hoped that the suggestion made in this report may be used to create a more sensitive system which works towards preventing such disagreements from reaching conflict status.

We observed that the later we became involved the higher the tensions and frustration, and the less likely were participants to be flexible. Instead, it became apparent that it would be more beneficial to get involved much earlier and work alongside the clinicians. Our focus became less about mediation and meeting in the middle and more about providing information which would help the process. We realised that the aim should not be mediation, but a consultancy service. However, such a service could only work in wards that accept such a service through appropriate training. There was not enough time to properly prime the clinicians and the wards for such an approach; the ideal situation will be discussed below in the section that discusses suggestions for future services. What we can say, however, is that necessary factors leading to success are clinicians who want to change and a consultancy service that helps them to facilitate this change. And this is what we found to be a necessary key to our cases that can be considered “successful”.

Although this approach would be much more difficult to assess, as the clinicians may be unaware of the input, it was decided that it would be the most beneficial. We decided to observe which suggestions and information were utilised by whom and record our success in terms of this. In regards to evaluation, this new approach needed a new way to evaluate the impact of the interventions. Initially we were going to evaluate by looking at compliance with care plans, but we decided that this would not be possible. One reason for this is time constraints. With such a small and short project it is difficult to assess the impact. Instead, we decided to observe the impact of the process and the information given on subsequent decision-making. Thus, we may need to estimate what would happen if we were not involved and what changed as a result of our participation.

Initially it was our intention to restrict criteria to those experiencing their first or second psychotic episode. We believed that it would be important to intervene with patients who had not altered their models as a result of numerous interactions with the mental health service. We also wanted to involve patients before they had had unsatisfactory experiences before they were beginning to disengage. Although the majority of patients were from this group, others were not. We found that maintaining this criteria would mean that we would not have enough subjects and we would be ignoring individuals who might benefit from involvement in this project. We found that often clinicians would request the intervention or the service for clients with whom they had contact previously. Doctors would consult the service for help with a client that had bounced back to care on several occasions. The clinicians expressed the concern that such individuals were bouncing back because of lack of compliance and lack of common understanding between client and clinicians. Indeed, one of the cases
which was considered successful involved a service user who had been admitted to hospital on at least four occasions. Thus, we found that we could help individuals who had experienced previous (unsatisfactory) contact with the mental health service.

The actual methodology had to be flexible in order to suit each case. Initially the project set out to see each patient on 5-6 occasions. It soon became apparent that each individual case would require different levels of interaction. Some individuals required far more interaction as a result of being in the service longer and being moved often between wards. Similarly, some individuals asked to be seen on more occasions and would contact me often. However, most cases followed a similar pattern. Once the person had been referred either by themselves or the clinical team, I would go to see them as soon as possible. At this first meeting I would talk to the person and tell them about the project. Explaining the project became key to the first interaction as many individuals seemed not to understand my role and what I could and could not do. I would then give the person additional information about the project and suggest that I come back the next day to see if they would like to take part. At this time I would also meet with someone on the ward to hear their understanding of the person and the nature of the disagreement.

I would then return and have usually two in-depth interviews with the individual in order to investigate the individual’s conception of the illness. If possible, I would also meet with family members on one or two occasions. At this point I would conduct research, if necessary, to find out more about the person’s religion or cultural beliefs. I would also meet with the clinician, if possible, to discuss their understanding of the individual’s illness. A report based on all the above information was then passed on to the clinical team as quickly as possible. I would then meet with the clinician to discuss the findings and make suggestions. It is important to note, however, that this approach only worked on a number of occasions. In the cases where such methodology was possible, there was a positive intervention. The above-mentioned process was the most ideal process and was the most successful method.

After a few initial interviews with clients it became evident that Kleinman’s questions were not always ideal for our project. It is not possible to ask the questions cold. Instead, it was necessary to present them to people once I had spoken to them and understood more about their background and concerns. Kleinman’s questions also may not work in some situations because of their assumptions about notions of illness and personhood. In many cultures such notions are externalised. It is not about the individual, but problems and illness are seen in external terms: witchcraft, relations and the weather. Thus there is the very real possibility that Kleinman’s questions will not reveal anything. Thus, there is the need to bring in the external context. Most cultures simply do not think about individual agency in the way that Kleinman’s questions assume. Kleinman’s questions would also not work when the individual felt that there was
nothing “wrong” with them. If they did not consider their present experience as illness the questions became entirely inappropriate.

Finally, we decided not to use any questionnaires to measure factors such as social distance. We realised that because of the small numbers of clinicians involved the findings would not be valuable. As the clinicians were all aware of the nature of the project we felt that there would be too great a social desirability effect. This effect occurs because people have a tendency to present themselves in the best possible light to others. The social desirability effect “has been shown to threaten the validity of research” (French 1993). Furthermore, one of the main tenets of anthropology is that what people say they do and what they do may be markedly different. Thus, it was our intention to observe what clinical teams actually did and we were less interested in what they reported doing.
4. CASE STUDIES

ALLAM

I was contacted by a ward staff member (Ward A) about Allam and was told that he wanted to take part in the service. Then Allam contacted me directly and we arranged a meeting with him. I tried to meet up with Allam on several occasions, but when I would go to the ward he would be on leave or unable to talk. Ward staff were also not very helpful as they would tell me when to come in but would not tell Allam that I was coming or would not ensure that he would be there.

Allam is a Somalian man in his twenties who came to the UK as a refugee ten years ago. He had been on the ward since October and I was told that they were querying anxiety, transient delusional disorder, paranoia, and psychosis. His main complaints were somatic such as chest pain and he also believed that his liver was missing. I was told that on admission that the staff thought that he had a depressive episode with psychotic features, because of his complaints about his body which they felt were delusional. They also thought it might be drug induced psychosis as he was a chronic user of khat. I asked what they felt the nature of the conflict might be. It was suggested that it was because Allam thought that the use of khat is not a problem and that he thought that he should be hospitalised, but the clinical team disagreed with him on both counts.

When I finally met Allam, he explained that he wanted a diagnosis and he felt that he knew what was wrong with him and that he had anxiety. His main complaint was that he felt that he needed to stay in hospital for a longer period, but the clinical team felt he was well enough to go home. He explained that he thought his liver was not there and that he has to hold on to his side to hold it in. He explained that he kept going to his GP because of the pain in his liver and in his lungs. GP did lots of tests, but everything was fine.” He complained that the GP did not tell him that he was being referred to the Hospital and felt that he was tricked by his GP and his mother. He told me that the police hid at the GP surgery and then jumped at him and brought him to the ward in handcuffs which had made him very anxious and angry.

He said that he was not told that he was going to a “mental ward”, that he had been told that he was going to a place where there would be a doctor around all the time to assess him. He didn’t understand where he was because he wasn’t given any medicine at first so he felt like he was in a prison, that he was a prisoner. Allam also said that he thinks that they are here to have new medication tested on them. During the times I spoke to Allam he discussed medication often. He was happy to take medication and felt it was important to do so, but he often wanted to change his medication.

He told me that he lived alone in a flat, but saw his family often and sometimes stayed with his mother and his siblings. He had worked for 6 years, but had had...
an injury when he punched in a window at his mother’s house and had not yet gone back to work. He told me that not being able to work made him depressed. He explained his problem as anxiety and panic attacks. He told me that his friend had died in February and he had begun to feel ill a few months later. He also explained that he was worried that his liver was not there. He explained that sometimes he thought it was not there and at other times he felt it was falling down and he had to hold it in. He thought the ‘accident’ caused his problems, meaning the time when he punched the window and incurred severe injuries to his hand. He also explained that he was worried about TB because someone he knew had become very sick with TB.

With regards to treatment, Allam said that he thought that anxiety medication would help as would a longer stay in the hospital so that he could “calm down.” He said, “when I go to my house I want to feel good and strong. Now I go home I still feel sick. I need more time to relax.” He also suggested that things were more difficult now as before he didn’t need anybody, but now he had to ask his family and friends for money and help.

After this initial meeting, I met with Allam on and off for several months. Indeed, at the time of writing this, Allam was still on one of the wards. I often had great difficulty in seeing him as he was often sleeping, on leave, or AWOL. One week after my first meeting with him I had planned to go see him once again and was called by a staff member to say that there was no point in me visiting him as he was being evicted from the ward as he was refusing to go. I was asked to attend the ward round the next week to discuss his case. The ward round consisted of myself, his GP, his two clinicians, two student doctors, the ward manager and a psychologist. It was explained that he kept appearing at the GP’s surgery and at one time became very agitated and this is what led him to being taken to the ward. He was given a low dosage of anti-psychotics after which they felt he improved somewhat. His psychotic symptoms subsided, but the somatic complaints continued. He had become very irritable and aggressive when he was told that he had to leave the ward. He was evicted and returned to smash the front door with a fire extinguisher. I was told that he did this very calmly and waited for the police to come. He was arrested and released on bail. The clinicians were concerned as he had threatened two of them. Once he had been released from police custody he had called the ambulance service 12 times and had tried to go to the A&E repeatedly. The ward round was predominantly about staff safety and how to manage him as they had agreed not to accept him back to that particular hospital. It was suggested that he would be referred to an addiction treatment centre.

I arranged to discuss this case with a Somalian clinician who had seen Allam some months before. One interesting point that this discussion raised was in regards to the complaints about his liver. The clinician explained that in Somali there is a common saying which translates to “his liver is removed” or “his liver is taken away.” Such a saying is used to refer to a male child who is a coward or
not assertive. There was also the suggestion that there may be issues of identity in this case. I also arranged to meet with Allam’s clinician who said that he had several different problems. She believed that his main problem was his khat use which altered his behaviour and his mental health. He was described as insightless. She explained that he had “dis-social behaviour” which may or may not be independent of khat use and that he had somatoform disorder and symptoms of anxiety which again may or may not be related to his khat use, which was regarded as the biggest contributing factor to his illness. Although I had gained information about Allam’s perception of his problems and how those ideas conflicted with those of his clinical team; it was not possible to do much as he had been evicted from the ward and it did not appear that the same clinical team would continue with any treatment.

A month after he was evicted from Ward A I received a call saying that he had been admitted to a private clinic in north London (Ward B). I went to the clinic and met with his clinician. At this time I was told that Allam was very concerned about people doing harm to him by looking at him in a certain way, particularly women. He came to be on this ward because he was “paranoid” and was “behaving in a threatening way.” The police were called and he was taken to the ward he was previously on, but they would not take him so he was sent to the ward he was on presently. I was also told that Allam thinks that his heart is poisoned. The doctor felt that khat was a major contributing factor to his illness, but felt that he was “insightful” because Allam acknowledged that the drugs were making him this way.

It was not until March that I was able to meet with Allam again when he had been transferred to a different ward (Ward C) in Lambeth. We discussed in more depth the things we had spoken about before and discussed his family and his past. I also attended ward rounds about Allam at the request of the clinical team. At this time his physical complaints were still a focus for him, although his complaints changed frequently. During the ward round his history was given and it was explained that there were no psychotic symptoms when he was first admitted to the first ward. They also explained that he had been banned from this ward, but they were unsure why that was. I noted that this conflicted with what I had been told by the staff on the first ward who had seen Allam as having psychotic symptoms. Also, this lack of knowledge about why he was evicted suggests that information is not being transferred completely and appropriately. I tried on several occasions to meet with Allam’s clinician’s to interview them about their perspective’s about his illness, but my requests were largely ignored.

Allam was then transferred briefly to Ward A- the ward he had originally been admitted to many months ago. He was then moved on almost immediately to another ward (Ward D) in Lambeth. I had tried on many occasions to meet with his mother and was finally able to meet with her in May. Her main concern was that nobody had told her what was wrong with him and they kept transferring him. She felt that every time he was transferred the doctors started from the
beginning. She explained his problems mainly in terms of his relationship with his family and with others. “He doesn’t trust people on the street. Said that people were stealing his soul. He is talking too much, before he was very shy. Now he is talking a lot and to others. Before he only talked to the family, now he’s changed and talks to everyone.” She felt that the chief problems his sickness caused were: “fighting, breaks windows, fights with family and people outside.” She explained that she felt his main problem was khat.

Allam’s mother also explained to me the causation for illness in the Somalian system. She explained that people became ill as a result of sudden fright or as a result of shock. “We are Muslims and we believe in the God and the Koran. If someone is sick we read the Koran and they get better. There is no solution in the hospital. The person is taken to a religious person.” She also told me that she has asked Allam if he would go back to Africa with her and stay with his father as she thinks that this would help him. She said that Allam is not religious here and that is a problem. She does think, however, that “doing something religious, reading the Koran would help. It helps others.” She explained that her friends and family think that she should call religious people to help Allam. She told me that she did not feel comfortable telling the doctors about this. She believes it will help him, but she does not want to interfere with what the doctors are doing.

I then went to see Allam on Ward D. He had gone AWOL and I was told that the staff were quite annoyed with him. He had been chewing khat on the wards and set fire to his mattress. I then spoke to him, but he said he was very tired. He again said he felt that he had anxiety problems and said he was worried about his heart. After speaking to him briefly, as he didn’t want to discuss things further, I was asked to join the ward round. I had written a brief summary about Allam in preparation for discussing his case with his clinician. In the ward round I was told that this was not the time to be discussing these issues as he hadn’t “settled down.” I was told that they were having to be coercive and restrictive and haven’t yet been able to engage with him. His clinician suggested that khat was not the main problem. I was able to give the clinical team the report I had written which summarized the things I had discussed with both Allam and his mother.

The information given to the clinical team was not utilised, however, because a week later I called the ward to find out what was happening to Allam and was informed that he had been transferred to another ward (Ward E). When I called Ward E I was told that he was not on the ward and had been moved back to “where he had come from.” From what I understand he was transferred twice more and then went back to Ward C. I went to the ward to find out what was happening to Allam. At this point I was told that the staff was unsure as to why he had been transferred back to this ward as it is an acute ward. I was also told that he had been diagnosed with schizophrenia of the paranoid type.
At this point I was invited to a ward round on Ward C. At this time I was able to give some feedback about the things I had discussed with Allam and his mother. I suggested that there may be a need for family therapy or family intervention as many of the problems seem to stem from family relationships. Similarly, both Allam and his mother seemed to explain some of his problems in this way. Research would also suggest that Somalian belief systems would place problems in the realm of disharmony in the family and amongst other relationships. Interestingly, a forensic report suggested a similar approach. At this point I suggested that there may also be issues about identity adding to Allam’s distress, this, however, was rejected by one of the clinicians. When I discussed the themes which I thought might be important to Allam’s case one of the clinicians seemed completely dismissive. The clinician responded to my suggestions by saying that such issues would not “make him mad”. This statement reveals the fact that this particular clinician simply was not open to incorporating such suggestions into his assessment and care. Although I had more information, there was not the time given to further discuss these matters and I felt that my input was not welcomed. At this point I suggested that I give the clinical team a short written report. They suggested that this would be helpful. They also asked that I also give a summary of incidents, because they did not have his notes as they had been lost in one of the transfers. It was clear that there was not a clear idea of Allam’s history which made assessment and a clear understanding of his problems difficult.

I soon realised that my comments and suggestions were not being incorporated readily and decided to stop the intervention once I had given the clinicians all relevant information in a report which they could then use as they wished. In addition to the comments about family therapy and identity issues, I also suggested that Allam had had a number of different diagnoses and neither he nor his mother were ever told about these diagnoses. I also suggested that at the beginning of my meetings with him it appeared that he was using somatic symptoms to communicate distress. I gave some additional information about the way people in many cultures use somatic symptoms or talk of bodily illness as “idioms of distress.” His somatic complaints seemed to fit into the Somalian context as well as his concern about his friends death and his concerns about TB. Furthermore, I suggested that it may be helpful in this context to see illness as communication.

Weiss et al. (1995) suggest that epidemiologic Catchment Area (ECA) studies in the US indicate the value of “reconsidering previously held notions about the distinctiveness and clinical boundaries of depressive, anxiety and somatoform (DAS) disorders” (p.153). Based on their analysis of ECA data, Simon and VonKorff (1991) show that interrelationships among these disorders are more complex than might be expected from the clear-cut diagnostic hierarchies outlined in the classificatory systems. Furthermore, to clarify the relationship “between the patient’s experience and professional theory, it is necessary not only to consider clinical problems with respect to a professional nosology, but
also to examine dimensions of distress from patients' point of view, with reference to the social and cultural groups to which they belong and which give meaning to these experiences" (Weiss et al 1995:358). I also suggested that symbols may be metaphors drawn from the body to express distress.

I also added that his mother felt that a ritual reading of the Koran may be helpful. In general I suggested that Allam must be seen in a wider context, understanding that his distress may, in part, arise out of his situation wherein he is the eldest boy who arrived in this country as a refugee. Such a move seems to have resulted in his father being separated from the family and creating a new family, a lack of discipline and the breakdown of normal familial ties. I also suggested that his mother's beliefs must be taken into account.

When the evaluation forms were returned I found that both Allam and his mother found the intervention helpful. Both said that they enjoyed talking to me and found discussing their perceptions of his problems helpful. Both the Senior House Officer and the Senior consultant, were both involved and worked together with the mediator on this particular case. Surprisingly, their evaluations were completely different even though they were both present in the same meetings and were given the same information. Although one found the intervention unhelpful and even potentially harmful and was entirely negative about such a service, the senior consultant found the mediation helpful and positive. Whilst the SHO said that the service did not help in any way, the Senior consultant suggested that the suggestions and comments were taken into account and did alter the perception of the person's problems, the assessment and the treatment plan.

At this time the problems with the study were emerging. There was growing tension with my participation on this particular ward (Ward C) and there was much confusion about my role. It is important to note that the majority of the "mediation" was attempted during Allam's time on Ward C as this is where he remained for the greatest period of time. However, I think it is also relevant that the clinician with whom I had the most contact was extremely negative about the project and did not seem to understand the approach, as was evidenced in the evaluation forms. Allam's case itself was difficult in that the constant moves made it difficult to liaise with staff and to mediate in any capacity. As his care kept being transferred, it was unclear which clinical team I should work with and which clinician I should interview about his illness. Because of the constant moves and impediments to interviewing both the client and the clinicians, the mediation process was greatly undermined. Any transfer of information was delayed for many months as I was trying to gather sufficient information. Allam's explanation for his problems constantly changed and developed, which is to be expected. He often seemed to incorporate explanations from other patients or in ways that he thought would help him to receive the treatment he felt he wanted. I saw him as learning and using other languages of distress, illustrating the changing nature of explanatory models. This study is intended to highlight not
only the difficulties encountered by the project, but also the failures of the organisation which impedes clear lines of communication, the transfer of information, and consistency of care.

As discussed above, this and other early cases illustrated that the initial approach and methodology was not working as we had hoped. Two additional case studies are described below; these two cases were approached using the modified strategy described in the previous section.

LISA

Lisa’s clinician referred this patient to me as he felt that she was not complying with medication and had a different perspective towards her illness than he did. Lisa was an inpatient on one of the wards and was under section. She had been diagnosed with paranoid schizophrenia and the nature of the disagreement lay in the fact that she had a history of poor compliance with medication and did not accept that her illness represented a brain disorder. Lisa is in her thirties, her family is from Nigeria and she herself has spent much of her adult life in that country. Lisa had first presented to the mental health services two years previously and she had had three episodes of psychoses in the past six months. Thus, her clinician felt that a new approach might be necessary to prevent future relapses.

I was introduced to Lisa by her clinician who had previously spoken to her about the service. The first time I met with Lisa was on the ward and we had our first interview there. She was interested in the service and was eager to take part. I asked her what she felt was the nature of the disagreement, she said that she thought that relaxing and feeling positive will help her, but that “they” (meaning the clinical team) said that these things didn't matter and all they thought about was medication. She also thought that her problems might be psychological, but felt that her doctor thought that all she needed was medication. She explained that she felt that counseling might help her to get better and to stay well.

During my first meeting with Lisa I collected general demographic information and asked her about her family and her past illness experiences. I also administered the insight measure to her. Out of all my clients, Lisa scored the highest on the scale, scoring 7.5 out of a possible 12 points. This would resonate with the fact that when I met with her she was beginning to accept the clinician’s model of her illness, unlike out other clients.

I was also able to meet with Lisa's clinician to discuss Lisa’s condition and his understanding of her illness. Throughout the intervention, her clinician and I were in contact discussing my findings who explained that Lisa had been diagnosed as a paranoid schizophrenic and that her condition was quite severe as she was sometimes violent, had a very rapid onset, and became stuporous.
He stressed the fact that it is a brain disorder and is due to a chemical imbalance. He also explained that there were different perspectives on this illness and he agreed that it was useful to look at stressors and also cultural factors to better understand the individual situation. In terms of treatment, the doctor felt that it was imperative that Lisa understood her need for medication and that she could remain well if she continued to take her medication. He also felt that education for Lisa and her family about the illness would also be an important aspect to her treatment. He was slightly concerned about her religious beliefs as he knew very little about them and thought there may be the possibility that she was getting contradictory information from the church. He also suggested that if there were beliefs about exorcism in the church she ascribed to, then there may be some conflict.

When asked what her problem was she responded, “I know there is a problem- it is a problem with my mind. The way I think, the way I perceive things. My judgement and perception of things is wrong. I know it’s something to do with my mind. My mind is not functioning in a normal way”. When asked what she called her problem she responded, “I think it is … mental illness. I am just saying what I feel, I don’t really have a name for it”. She explained that she was not aware that others called her problem schizophrenia until her GP wrote her a letter in support of her claim for housing. At this time he wrote in the letter that she had a diagnosis of schizophrenia. Lisa also explained that she felt that fear and overtaxing herself led to her subsequent illness episodes. She said that she was so worried about becoming ill again as she thought that she would not get better and this caused her anxiety and eventually caused her to relapse. She felt that her illness began when it did because of the things in her life that happened to her. At this time, she explained, “I did not have a confidante and so I tried to deal with things myself”.

Lisa hesitantly spoke about her church and her faith. I would suggest that this may have been because she felt that the clinical environment may be sceptical or critical of these beliefs. She slowly did get more comfortable talking about her beliefs and her involvement in the church. It became clear that both were a major part of her life and consumed much of her time. She explained that in the past year she had become much more involved in the church and went there more frequently. Lisa said that this was because she felt it gave her something positive to do. She felt that prayer was very important and as a Christian one would pray to get better. She felt that this could complement any medical intervention.

Lisa felt that being on medication was one of the main problems that her sickness had caused her. She expressed a very negative view of medication and seemed to want to get off of it as soon as possible.

Lisa came to realise that her approach was not completely effective, as she had experienced so many relapses in such a short period of time. The doctor gave
her literature about schizophrenia and she found this extremely helpful. She also felt that learning from others who had the illness and reading accounts by people who were living with the condition would be helpful. She stated that she felt that talking about her illness and her experiences, counseling and/or group meetings would be helpful. Lisa always maintained, however, that there were factors that she felt were important to her well-being that the clinical team were not taking into account. These other factors included having a positive mental attitude, prayer, talking about her experiences, learning from others who have learned to live with the condition, and having a confidante.

For our second meeting I went to see Lisa at her mother’s house where she was staying until she felt better. She spoke more about her perception of things. She said that she was starting to understand what schizophrenia was and explained it to me in terms of a chemical imbalance. We again spoke of her church and how much she felt it helped her. She explained that it was very important that she had people around her and people who pray with her and support her. Once again she said that she felt that other things affected her illness— that it was not completely down to the chemical imbalance. She said she felt that it might be something to do with her personality, stress, being too sensitive and psychology. She said that her doctor said that it was not due to these factors.

I also met with Lisa’s mother, Sara, to gain an understanding of how she understood Lisa’s problems. Her mother felt that a series of stresses caused her daughter’s problems: financial problems, having nowhere to live, and her relationships. Sara noted that Lisa cut herself off from people and would keep things inside herself and this was part of the reason that she fell ill. Sara also stressed that they were religious people and prayer was of the upmost importance. She also told me that their pastor and family friend lives close by and was present during Lisa’s first episode of illness. The same pastor would go to the hospital to pray with Lisa when she was ill. She feels, however, that sometimes Lisa prays too much and this is not a good thing. Sara also told me that Lisa fasts as it is a regular part of their beliefs, but sometimes when Lisa fasts she does not take her medication.

After meeting with Lisa and her mother I did some research to discover more about their church and its particular brand of Christianity. This research helped in building a better understanding of the religious beliefs of Lisa’s church and the way it may affect her treatment plan. I was then able to combine the information collected and present this information in the form of a report to her clinician. It would have been better to gain an understanding of the church by talking with Lisa and her family, but Lisa went away for some period of time at this point and also seemed somewhat reluctant to enter into in-depth conversation about the church.

Such research is typical of what social scientist do to gain a better understanding of a context. However, it is unlikely that a clinician would conduct such research.
Thus, there either needs to be a service which can help him or her do so, or they must learn skills to communicate with their clients about such issues. Indeed, although a background understanding of such things through independent research is helpful, it is most helpful to gain an understanding from the individual themselves. This is due to the fact that the individual’s understanding of the beliefs and practices may not be exactly in line with those of their church or their church leader.

One of the main suggestions would be to better understand the beliefs of the church and to try to build up a relationship between Lisa’s church and the mental health services working with her. This may help to understand the kind of messages she is getting from the church and would also help to deal with issues such as her fasting. The CAC is one of a large group of West African Independent (or Indigenous) Churches. In particular, they claim to depend on God alone for healing. Illness may be seen as being caused by spirits or demons. Nigerians (not just CAC members) combine belief in the spiritual world with other aspects like belief in witchcraft, where one can cause harm to another. Religion can be seen as guidance against this evil and divine power and protection can be made available. Their lifeworld is strongly influenced by the spiritual, but at the same time they are conventional and ambitious. (Peel, personal communication 2001). As Dr. Thomspson states, “such problems (illness) may be seen as solvable by faith and prayer. It is possible, therefore, that a member of CAC may not accept a Western diagnosis of schizophrenia. This does not mean that the patient is unreasonable or irrational: a perfectly healthy member of the church may have the same cosmology” (personal communication 2001).

Education is another main focus for my suggestions. Education for Lisa is important, but more important may be education for her mother and the rest of the family. Specifically, there may be a need to emphasise to her mother that it is not Lisa’s personality that made her ill, but work with her understandings of her daughter’s illness. Lisa seemed to respond very well to being given literature about her illness and seemed to appreciate this approach. As Lisa was well-educated and enjoyed reading, it was a very positive way to explain her doctor’s understanding of her illness.

Lisa's clinician was open to my suggestions and thought he could better draw together her notions about the illness. The main points contained in the report were the fact that a successful treatment plan would have to better incorporate Lisa’s beliefs about her illness. I also suggested that Lisa’s and her family’s religion should be discussed and incorporated into her treatment plan. Opening up the lines of communication with her family and her religious community would help to approach Lisa’s illness and recovery in a more complete and holistic way. Thus, acknowledging prayer as an integral aspect of her well-being can only benefit Lisa. Similarly, opening up discussion with her pastor would allow for cooperation and help in her continuing care. Her pastor could also help to clarify
some of the issues discussed with Lisa. He could also help in such situations as encouraging her to continue taking medication whilst fasting and finding a way to make this possible. For example, he might be able to excuse her from fasting, or enable her to do a partial fast.

Another suggestion was that the clinician could better incorporate Lisa's views into her treatment plan. Instead of dismissing her belief that a positive mental attitude will help her recovery, he could incorporate these ideas and give her more of a role in her own recovery. Lisa said that she believes that setting realistic goals helps her to stay well and this could easily be part of the ongoing process of her care.

This case was one of the cases which I considered a success. I will explain below in more depth as to what I mean by success. In the follow-up evaluation forms Lisa, her mother and her clinician wrote very positively about the affects of the service. The intervention seemed to change the course of the treatment plan to some extent and when I last met with Lisa she was doing well, was going back to work and continuing with the treatment plan. Although her care was transferred to another doctor, as her doctor changed jobs, Lisa seemed content with her relationship with her doctor and said that she would definitely maintain contact with the mental health service.

In his evaluation, the clinician said, “this sort of mediation service is very helpful in analysing the attributes and beliefs of both patient and doctor so that a compromise can be reached.” He continued to suggests that the service “helped to find a middle ground with regard to her treatment package to improve compliance with treatment ultimately.” He also felt that it improved his perception of the Lisa’s problems by putting them “in a more detailed cultural context.” He suggested that such a service was necessary in that “it was very useful in improving engagement with the service and compliance with treatment.” Overall, he found the service helpful and necessary, believing it altered his relationship with his patient and his patient's family. He said that the service benefitted his assessment of the person’s problems, the treatment plan, and compliance. The only thing he felt it did not alter was diagnosis. He felt that such a service should be made available to “patients from all minority cultures” and should be combined with a translation service so that patients can be free to talk in their first language.

Lisa also said she was grateful for the service and said she found the service helpful. “I was able to express my own opinion and discuss at length with the mediator.” She felt that being able to talk about her experiences helped her and she felt it changed, for the better, her relationship with her doctor. “Each time I met up with my doctor I trust his opinions better.” She felt that it changed her treatment and she felt the service helped her to be listened to by her doctors. She said that she felt that she would approach the mental health services again if she became ill again.
MR. L

Mr. L. was referred by his psychiatrist, Dr. K, after being seen in the outpatients department. He is a 50 year old man originally from Jamaica who has no previous history of mental illness. I was told that Mr. L was diagnosed with psychosis, but he does not feel that he is mentally ill, but feels that his problems are due to a voodoo curse being placed upon him some years ago. He had been put on anti-psychotic medication and an appointment was made for him a month later. After meeting with his doctor, we decided that it would be best to get the mediator involved immediately before any frustrations or disagreements had a chance to firmly take hold. This was an opportunity for the service to get involved immediately and attempt to subvert the process whilst working alongside doctor and service user. Dr. wrote a letter to Mr. L suggesting that he contact the service to discuss his understanding of his problems. The mediator also wrote to Mr. L.

Mr. L did not respond to either letter and instead it was arranged that the mediator would attend the next scheduled outpatient’s appointment with Mr. L to discuss the service with him. The mediator was introduced to Mr. L before his appointment and he agreed to meet privately with the mediator to discuss the service. He was interested in taking part and suggested that he felt that he would be willing to do anything that might help his situation. Mr. L. began the conversation by asking if I knew anything about voodoo. He explained that his problems all started when his children’s mother got into an argument with a man over money. He said that this man was a very dangerous and powerful man and now “bad luck seemed to be following me”. He then listed a number of accidents and misfortunes that had befallen him since the argument. He had been to see a preacher, but he felt he couldn't tell the preacher much about it and he felt that the preacher couldn't make sense of it. His friend took him to see a voodoo practitioner to see if he could get help. Mr. L told me that the woman had told him that he had evil spirits surrounding him and that she could help him, but only for £500. The woman told him to carry around three limes and three cloves of garlic to protect himself. He then showed me these articles and explained that he would also squeeze a lime on his doorstep to protect himself.

When asked what was causing his problems he explained, “they call it obeah, this is what voodoo is.” He knew it was voodoo because the man with whom his children’s mother fought was from an area in Jamaica where there is strong voodoo. When asked what his friends and family thought about what was happening to him he explained that some felt it was voodoo and others did not agree. He said that when he lived in Jamaica he was not concerned about voodoo- he never really thought about it. Mr. L and the mediator arranged to meet at his house later in the week to further discuss his situation.
At the beginning of the project I met with Valerie Graham from ‘Diverse Minds’. She mentioned obeah immediately and said that I should be aware of this system of beliefs as many Afro-Caribbeans explained misfortune and illness in these terms. I found it interesting that many clinicians did not know about this term and would suggest that as it seems so prevalent amongst this community, it should be something that should be taught to health workers who will be working with Afro-Caribbeans. Obeah is one way to talk about suffering and the clinician could have picked this up and talked about the experience in terms of the client’s understanding. This case is illustrative of the fact that you can talk about suffering in many different ways.

When I arrived at his flat for our second meeting there were candles burning beside three limes and the room smelt powerfully of garlic. Mr. L explained that this was to protect him. The flat was sparse but very clean. He explained, “I am trying to keep my mind calm.” I asked if he felt the medication he was taking was helping him and he responded, “I think it is helping me to be calm.” Mr. L explained that the prayers given to him by a priest friend and the medication helped to calm him down, but he did not feel that they would cure him or solve his problem. Thus, the cause, the ‘why’, had to be fixed before he would begin to get better. This pointed to the need to solve his problems based on his understanding of the problem, thus, it would be necessary to bring in a traditional healer or a religious leader to make sure Mr.L felt the root of the problem had been resolved. On the Birchwood Insight Scale Mr. L scored 1 out of 12, a score which pointed to extremely low insight. However, Mr. L was clear that there was something seriously wrong with him and that he needed help. Thus, here we see that such insight scales measure whether the client agrees with the clinical assessment: i.e. do they call their problems a “mental illness”, do they think they need psychiatric help, and do they think they need medication.

I asked him what had caused his problem and he explained, “the incident”. He explained that the mother of his children, from whom he was separated, was having building works done to her home. The man doing the work had not done a good job, so she refused to pay him all the money he was demanding. The man got angry with her, threatened her and then started chasing her with a machete. Mr. L then intervened and the two men struggled with the knife. Whilst they were wrestling for the machete they both got cut. Mr. L then told me that the other man pressed charges against him for his injuries. He then started talking about obeah and his misfortunes. I asked him when he realised that it was obeah. He explained, “I realised right after the incident in the courthouse….the man was supposed to stay on the other side, but he came right in front of me (points to the ground in front of his feet) and stepped on my feet. He came over and dusted this white powder on me. A few days later I noticed my foot was infected. I went to the doctor to show him, but he said it was infected from something else….Also in the courtroom the man was talking to the judge and making funny movements. When it was my turn to speak I couldn’t speak, my tongue was heavy.” He explained that he was charged because he couldn’t
defend himself because he couldn’t speak. He then told me that right after that he noticed all these minor incidents. He started to have bad dreams, “like I was doing community work, gardening, and then all of a sudden I was in the ground, a grave, and people were throwing dirt on me…The dreams are worrying because you don’t know what’s going to happen. You wake up before you see what happens and this is worrying.

Mr. L’s case differs from all the other cases in that he was referred by his GP. I asked him how he came to meet with Dr. K. “I went to my GP and was referred there. I went to the GP for all the injuries and then because I was feeling low. I was having flashback of the fight.” Thus, we can see that Mr. L’s pathway into care was much more positive in that the police weren’t involved and he was able to get help whilst remaining an outpatient.

I asked Mr. L what kind of treatment he should receive. He responded, “I went to a priest and he gave me some prayers, so I read those and they make me feel calmer. I sit and read them and meditate.” I asked what church the priest was from. “I don’t know. He is a black man, not a Roman Catholic priest.” I then asked him what sort of help he wanted from the doctors: “The medication and prayers help to calm me down.” But he explained that they helped him, but would not cure him. So what would cure him, I asked. “One thing that would help is to move flats. Maybe the house is cursed. I see shadows moving and get the shakes. Some of my friends say I should see Mary Anne [the voodoo practitioner he had seen before]. That is the only thing that will cure me because she is really good.

The mediator was in constant contact with Dr. K feeding back to him what the discussion and subsequent research uncovered about Mr. L’s case. After his second meeting with Mr. L, Dr. K expressed disappointment in the fact that the medication was not working and expressed some concern that Mr. L was actually taking his medication. Although Mr. L says that he is taking his medication, Dr. K is not convinced as there has been no change in his state of mind. Dr. K says that Mr. L is only taking the medication on the basis that it helps him to sleep.

When I discussed the case with Dr. K, I asked him about his interpretation of Mr. L’s problems. He explained that it was difficult to assess because in the manual it says that the delusions should not be appropriate to their culture. When asked what he thinks caused his problem he suggested that it was the stress of the court case and it arose rapidly from this point. As one can see from this explanation, Dr. K incorporated social features into the discussion about Mr. L’s illness. Dr. K recognised that the diagnosis of psychosis was problematic in this case because the definition of delusion is supposed to be culturally inappropriate. Although he did recognise this, Dr. K did not seem to be convinced that this pointed to the fact that Mr. L was not delusional as the things he was describing were culturally appropriate. In many ways this case is all about rationality and irrationality and who judges beliefs and behaviour as rational. This case is also
largely about communication. It illustrates clearly that clinicians need the tools to get them to communicate effectively cross-culturally. Dr. K’s concern for Mr. L was that his sickness meant that he was constantly preoccupied with ideas about voodoo and was quite disabled by it.

During the first feedback session Dr. K asked if I thought that Mr. L was psychotic. I explained that from my initial discussion with Mr. L it seemed that he was behaving in a culturally appropriate way and that others around him were supporting his behaviour and his beliefs. The very fact that Dr. K asked my opinion of the client points to the fact that he was open-minded and interested in other opinions about the person in his care. Dr. K said that he believed that Mr. L had psychotic symptoms and one aspect which helped him to reach this conclusion was that Mr. L’s belief in voodoo came on suddenly and he did not have these beliefs before. I suggested that it is not abnormal for people to reach for explanations for distress and misfortune and these systems will be something that they are familiar with, but may not be something that to which they originally subscribed.

After meeting with Mr. L, the mediator did a small amount of research on voodoo, obeah, idioms of distress and the presence of voodoo practitioners. The mediator then wrote a report about Mr. L and the subsequent research and gave it to Dr. K. The main points of the report were:
1. That it may be helpful to see Mr. L’s symptoms in terms of depression. Indeed, as Littlewood (1992) suggests, depression is often misdiagnosed in black service users and this may be worth investigating. The patterns of physical symptoms of depression: sleep disturbances such as waking early in the morning, constipation, loss of energy and lassitude, difficulty in concentrating, loss of appetite and decreased sexual desire can be seen amongst Mr. L’s symptoms. Furthermore, Littlewood (1992) notes, symptoms such as these are very similar to those recorded in Africa and Australia in people dying of ‘voodoo death’. Mr. L himself said that he felt low and depressed in my interview with him and said he had gone to his GP to complain of his low mood. If medication was still deemed to be appropriate, anti-depressants would be more applicable to this situation (Littlewood, personal communication 2001).
2. That is appears that Mr. L is using voodoo to interpret his experiences over the past few years. It is not unusual for individuals to use a known, yet previously unused, language of distress. He is using a symbolic system which is powerfully known to him to cast meaning and to understand his misfortune and illness. It would seem that he behaving in a culturally appropriate way according to that community and those beliefs. Others around him have the same beliefs and are supporting his interpretation. However, some of his friends and family do not agree with such an explanation.
3. We can see Mr. L’s illness as communication and symbols, his idiom of distress. As Dein (1997) suggests, 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.

4. Mr. L. explained what was happening to him in terms of Obeah, or voodoo. Obeah is a prevalent belief amongst Afro-Caribbeans and involves the notion that it is possible to influence health or well-being 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 counter-measures are employed. As Dein (1997) suggests, a doctor presented with someone claiming to have been bewitched may misdiagnose a paranoid disorder and treat the patient with anti-psychotic 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. Thus, in the case of Mr. L. it may be important to work alongside a traditional healer or priest to try to reach a satisfactory conclusion to his problems.

5. It would be helpful to get his friends and family together to discuss his situation and come up with a suitable course of action. At this time it might be possible to locate a traditional healer that those around him trust, or if not, then a suitable religious leader. In discussing this case with Roland Littlewood, he suggested that there should be a ritual which would be an emotional event for Mr. L. This would be to ensure that he felt relieved of the curse and felt sufficiently protected. Littlewood further suggested that the ritual should all be focused on one day and not done in little increments. He suggested a major transitional ritual, such as praying all day and all night in a church. If there was guilt involved he should have some sort of confessional as part of the ritual.

6. Mr. L would benefit from being assigned a social worker. His benefits have been taken away because the doctor said he was fit to work, as he has supposedly recovered from the accident that hurt his back. But it is clear that he is unable to work as he is fearful whenever he has to leave his home. He said that he needs to move away from his flat or make it more comfortable. He does not have a working fridge or a satisfactory bed. He told me that he often resorts to sleeping on the floor, as the bed is so uncomfortable. It is clear that the lack of suitable living arrangements is adding to his distress.

After making such suggestions to Dr. K, Mr. L was put on anti-depressants. Dr. K suggested that he had though previously about depression in regards to Mr.L's case, but felt that the depression may be a result of his psychoses ie not being able to leave the house. Mr. L was also referred to the community team where the social worker first focused on meeting his housing needs. I also met with the social worker to discuss my suggestions with her and see if she could arrange the family meeting suggested above.
After a few months, Mr. L was seen by the community team, who focused on his benefit needs and making his flat more suitably furnished. I met with his CPN to further discuss his case and pass on the information I had discovered by research and discussing things with Mr. L.

Both Mr. L and Dr. K were positive in their evaluation of the mediation service. Both found it helpful and it was clear that his treatment would have taken a very different path without the early intervention of the mediation service. In the evaluation form, Dr. K said that the service improved the relationship with the client, saying that the service “allowed for a better rapport with the patient. Patient felt that his views were being taken seriously and that we were interested in his problems.” He said that the service altered the perception of the person’s problems, the diagnosis and the assessment, the treatment plan, and the patient’s compliance with the treatment plan. Thus, it would seem that the service benefited the interaction in every regard. Mr. L said that he found the service helpful and felt that it helped him to be able to talk about his experiences. He also said that it improved his relationship with his doctor as it helped him to get his opinions listened to by his doctor.

There is some concern, however, about the extent to which my suggestions were followed through in this case. Although the clinician and Mr. L’s social worker found the comments helpful and did seem to alter the way they thought about and approached the case, it is unclear if all of what I suggested was carried through. Mr. L’s case came at the very end of the project and at the time of writing his case had just been passed on to a social worker. Although both the clinician and the social worker thought that the suggestions of bringing Mr. L’s family and friends together to attempt to find a way forward and that of bringing in a priest or a traditional healer helpful; it is not known whether this will actually be arranged. The social worker suggested that it may not be possible due to time constraints in that her focus, unfortunately, had to be on fundamental needs such as housing issues and benefits. Dr. K suggested in his evaluation form that these suggestions would have been better handled by me, pointing to the fact that the clinical team did not see it as within their realm of responsibilities. Dr K. said, “the main problem at present is for involved professionals to implement recommendations made i.e. arrange meetings/ find time to explore the necessary issues. I think a service that could take this burden away from the professional would be welcomed, but a service that made recommendation and then left these to the professionals to implement would probably meet more resistance.” Such a comment reveals the resistance to change in the clinical profession.

ELEMENTS OF SUCCESSFUL CASES

One must ask why I considered these two cases such a success as compared to the other cases. The other cases I felt were not successful until I received the evaluation forms from both clients and clinicians. At this point I had to alter my conclusions slightly, as both the clinicians and clients appeared to find the
service helpful. However, I consider the case of Mr. L and Lisa to be successful for other reasons. Not only were the evaluations favourable, but in these two cases I observed obvious changes due to the intervention of the service. Success was measured mainly due to the magnitude of change. These interventions appeared to change the course of the relationship and treatment more dramatically for the better. Although other cases could be seen as successful in that both clinician and patient expressed that the service helped their case, this case and the one before resulted in a change in the way the clinician thinks and acts. It seemed clear in these two cases that the intervention affected the course of the person’s care for the better. These two cases were different in that the clinicians involved seem to take on board my comments and suggestions and used them to alter their assessment and treatment regimes.

There are a number of factors which came together to make these situations of consultation a success. At this point I will look at the common features in these cases to investigate what made them more successful than the others. I would suggest that the most important factor which led to the success of these cases was the fact that they occurred after the modification of the approach and the methodology. Instead of a mediation approach, these cases were handled in terms of a consultancy. Instead of trying to find middle ground and mediate models, I focused on gathering information, mainly from the client and then speedily conveyed this information in the form of a report and discussions to the clinicians.

The early involvement of the researcher in the case of Mr. L allowed for the information to be provided before both parties became frustrated or welded to their position. Instead, the researcher was able to ensure that the relationship between the patient and the clinician remained positive. However, in the case of Lisa, she had already had a number of hospital admissions and was quite frustrated when I first met with her. Although I would suggest that earlier involvement is helpful, it appears not to be necessary. What emerged as a necessary component of a successful intervention and to instill change was an open environment and a substantial and rapid dose of the anthropological technique.

The fact that the patients were referred by the clinician means that the doctor saw that the help of the mediator could be beneficial. Indeed, the openness of the clinicians to the ideas presented by the client and the mediator made the process possible. The clinicians were able to question their assessments throughout, allowing themselves to use the information offered by the mediator. In both cases the doctors considered social factors causing the illness and were not focused only on a medical explanation. In the case of Mr. L, Dr. K was even able to question the diagnosis he had given, something that the other clinicians did not come close to considering. Indeed, I would suggest that the success of these two cases owes a great deal to the open-mindedness of the clinicians involved.
The fact that the patients approached the services voluntarily and took medication voluntarily had a huge impact on the success of the case. In the case of Mr. L, the fact that he was an outpatient throughout the entire process had a huge impact on the success of the case. Similarly, Lisa was discharged soon after I first met with her, meaning that the frustration of being sectioned was not present in either case. I think this is a major feature, as in the other cases the main focus for patients was the fact that they were being held in a ward against their will. This was their main point of contention and this was what they wanted me to resolve. Another factor which played a large part in the success of the involvement of the mediator was the fact that in these cases it was possible to use both the medical model and the patient’s model in a treatment plan. Treatment could combine both approaches in a way that both parties felt were acceptable. In the case of Mr. L the fact that the patient was subscribing to an established and well-known explanation system, voodoo, also made the situation easier to manage. This was also the case with Lisa, as I was able to do research independently to discover more about her belief system in regards to her religious affiliation.

Interestingly, both clinicians involved were not part of the initial advertising of the project. Lisa’s clinician was a community clinician with whom I had no previous contact. He saw the project advertised and contacted me immediately about Lisa. Dr. K was beginning his first psychiatry rotation and only came to South London and the Maudsley in April. It may be relevant that these two clinicians were not present for the launch of the project and the subsequent difficulties which arose at the beginning of the project. Thus, their preconceptions of the project may have been less tainted than those of other clinicians.

EVALUATIONS - Quantitative and qualitative results

During the project itself I felt that it was not very successful. However, when the clinicians, service users and the service user’s families returned their evaluation forms, a very different picture emerged. Of the seven clinicians who were involved in the project with either one or more patients, only one responded negatively in the evaluation form and one responded that their client had not engaged sufficiently with the project. The latter clinician thought such a service could be helpful, but that his particular experience with the project was not sufficient to comment upon it. Thus, four out of five clinicians whose patients engaged with the service found the mediation project helpful. One clinician said, it was “helpful to review patient with somebody from outside the service.” Another said, that the “project has served as a good reminder to be more acutely aware of the cultural background of the person. Additional written information [regarding one particular patient] was particularly useful.”

In total we had 17 referrals. There were other individuals who were brought to our attention, when I visited wards, but they were not interested in taking part at
this time. A few individuals did say they would be interested in taking part, but only once they were home and ready to discuss their experiences. Some said they were so frustrated and did not want to talk anymore about their illness. Of our referrals, four were not interested in taking part and one I was unable to contact. Thus, there were 12 people began to take part in the project. However, 4 of those who did take part either lost interest, disengaged, or were discharged and saw no need to continue. There were a number of reasons for people not continuing with the service. One person was discharged soon after I met with him and saw no need to continue as his main grievance was being held in the ward against his will. Another became frustrated as he saw that I was unable to make much difference as his clinicians were not accessible to my input. Another patient was transferred soon after my first meeting with him and seemed to have no real conflict, but simply wanted to talk with someone. Similarly, I often worked with people who also had recruited the help of the patient advocate. Often it was issues better dealt with by the advocate that were their main concern. I did not get evaluations from these people as it was clear that their engagement with the service was not sufficient to evaluate the role of the service. Three people were interested, but it was impossible to continue due to the project coming to an end and/or not getting adequate support from their clinicians.

We received evaluation forms back for seven patients from clinicians\(^\text{10}\). We also received evaluation forms from five of the patients, the exception being the patient whose clinician said he did not sufficiently engage with the service and one who did not want further contact once he had been discharged. We also received feedback from three family members who gave feedback about their experience of the service. Thus, we were only able to effectively evaluate the service in regards to five patients and, thus, the evaluations cannot be conclusive. They can only shed some light on the project and the feedback received from those involved. Because of the numbers involved the quantitative evaluation is not that important. The following is a summary of what happened in quantitative terms, but this does not capture what happened in qualitative terms. The qualitative aspect of the evaluations were far more important and resonated with the aim of the project. Thus, following the quantitative summary there will a review of some of the comments given by those involved. Qualitative evaluation also involved observations as to what actually occurred and these finding are central to the evaluation of the project.

Table 1: Clinicians’ evaluations

\(^{10}\) In the table above the focus was more on the general comments returned, rather than focusing on each specific case. The numbers may appear to not correspond because at times, more than one clinician worked with the same patient. Similarly, at times one clinician had a number of patients who were involved in the project. For example, we could receive three feedback forms from three different clinicians for the same case. Thus, the results above refer to comments per patient.
<table>
<thead>
<tr>
<th>Question</th>
<th>Clinicians’ response per case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you find the mediation project helpful?</td>
<td>7 Yes/ 2 No</td>
</tr>
<tr>
<td>Did the intervention alter your relationship with your patient?</td>
<td>3 Yes/ 6 No</td>
</tr>
<tr>
<td>Did the intervention alter your relationship with your patient’s family?</td>
<td>3 Yes/ 2 No/ 2 No</td>
</tr>
<tr>
<td>Only 5 cases involved interaction between clinician, mediator and family</td>
<td></td>
</tr>
<tr>
<td>Did the intervention alter your perception of the person’s problems?</td>
<td>7 Yes/ 2 No</td>
</tr>
<tr>
<td>Did the intervention alter your assessment?</td>
<td>5 Yes/ 4 No</td>
</tr>
<tr>
<td>Did the intervention alter your diagnosis?</td>
<td>2 Yes/ 7 No</td>
</tr>
<tr>
<td>Did the intervention alter the treatment plan?</td>
<td>5 Yes/ 4 No</td>
</tr>
<tr>
<td>Were you able to include the patient’s views and construction of their problem into your assessment and interaction with them?</td>
<td>5 Yes/ 4 No</td>
</tr>
<tr>
<td>Do you think such a service is necessary?</td>
<td>7 Yes/ 2 No</td>
</tr>
</tbody>
</table>

| Table 2: Clients’ evaluations                                           |
|-------------------------------------------------------------------------|------------------------------|
| Question                                                                 | Client’s response             |
| Did you find the mediation service helpful?                             | 4 Yes/ 1 No                  |
| Did being able to talk to the mediator about your experiences help you? | 5 Yes/ 0 No                  |
| Do you feel it changed                                                  |                              |
| Your relationship with your doctor?                                    | 2 Yes/ 3 No                  |
| For the better or worse?                                                | 2 Better/ 0 worse            |
| Your treatment?                                                         | 2 Yes/ 3 No                  |
| Do you think the service helped you being listened to/heard by your doctors? | 3 Yes/ 2 No                  |

The next set of questions was intended to assess if the person was satisfied with the care they received from the mental health service overall. As the project was intended to prevent people becoming dissatisfied and disengaging with or having a negative perception of the mental health service, we tried to assess whether the service resulted in a more positive experience which would affect future engagement with services.
If you had difficulties/became ill again would you approach the mental health service? 4 Yes/ 1 No

Were you satisfied with the care given to you by the mental health service? 3 Yes/ 2 No

Do you think you were more or less satisfied with the care received as a result of the involvement of the mediator? 3 More/ 1 na/1 Less

In two cases two clinicians, the Senior House Officer and the Senior consultant, were both involved and worked together with the mediator. Surprisingly, their evaluations were completely different even though they both present in the same meetings and were given the same information. Although one found the whole process unhelpful and even potentially harmful, the senior consultant found the mediation helpful and positive.

As mentioned above, all but one of the clinicians involved felt that the mediation service was helpful and necessary¹¹. One clinician stated, that the “project has served as a good reminder to be more acutely aware of the cultural background of the person. Additional written information [regarding one particular patient] was particularly useful.” The same clinician suggested that “it is always useful to comprehend the problem multidimensionally.” Another clinician said that “this sort of mediation service is very helpful in analysing the attitudes and beliefs of both patient and doctor so that a compromise can be reached…. [The service] helped us to find a middle ground with regard to her treatment package to improve compliance with treatment ultimately.” This same doctor said that the intervention of the researcher resulted in him altering his perception of his patient’s problems in that it “put them in a more detailed cultural context.” Another clinician said “The meetings with [the mediator] and the reading material gave me more tools to understand the patient’s perspective.” The same clinician said that the very presence of the mediator and the service made him alter his relationship with his patient.

The clinicians often cited the fact that the service added to rapport and trust and resulted in a better relationship between client and clinician. One clinician stated, the service “allowed for a better rapport with the patient. Patient felt that his views were being taken seriously and that we were interested in his problems….Again through encouraging rapport and trust in the professionals involved I think that compliance was encouraged.” He continued to suggest that such a service is necessary in that “as non-compliance is a major cause of readmission any measures that encourage this would be of great benefit to the

¹¹ The results show that two clinicians thought the service was unnecessary, this was actually the same clinician working on two different cases thus completing two separate evaluation forms.
health service and users.” Another doctor suggested that the service was “very useful in improving engagement with the service and compliance with treatment.”

In terms of diagnosis, assessment and treatment plans, the majority of clinicians felt that their assessment and treatment plans were improved but diagnosis was largely left unaltered. One clinician said, “by becoming more aware of the variety of views possibly involved in the crisis” the perception of the person’s problems were altered as was diagnosis and assessment. He continued, “diagnoses became more inclusive of personal values of patient.” In regards to the treatment plan, this clinician felt that the intervention of the mediator did alter the treatment plan as it became “more inclusive of psycho-social influences on the process of recovery.” Dr. K, whose case is dealt with above noted that the intervention altered his perception of his patient’s problems, the assessment, the treatment plan and the patient’s compliance with the treatment plan. He said, “The similarities between the idea of voodoo death and features of depression were interesting and even relevant to the choice of medical therapy….But the question of whether the underlying process was of a psychotic delusional nature or was a culturally appropriate response to circumstances remains unclear.”

In their evaluation forms, clinicians were asked to comment upon what they would like to see in future services of this kind. One doctor suggested that “the service should be available for patients of all minority cultures. In some cases it may be important to have a liaison worker who can speak the language of the patient’s first language.” Another clinician’s comments supported the findings of this report that suggests education and training as a necessary starting point. “More education of staff (all levels); participation on clinical meetings- not just for the patients being seen by the mediator; [anthropologist/mediator] should not be seen as part of the team.”

One clinician suggested, “the main problem at present is for involved professionals to implement recommendations made i.e. arrange meetings/ find time to explore the necessary issues. I think a service that could take this burden away from the professional would be welcomed, but a service that made recommendation and then left these to the professionals to implement would probably meet more resistance.” Such a comment reveals the resistance to change in the clinical profession.

Shortcomings of the service were commented upon by a few clinicians. One suggested that “one of the shortcomings of the project was the time spent with other staff members on an on-going basis. When the project officer was available her contribution was greatly appreciated.” Thus, in the future the suggestion is that the service be more involved and liaise more with ward staff and get their input on cases. The same clinician suggested that it is necessary to have an unbiased approach of mediation and that such a service may benefit in the future from a better choice of patients. The clinician felt that the particular patients with whom I worked with from her ward had extremely intricate problems
and may have not been ideal for such a pilot project. I would agree with her in that some of the patients did not seem to be those whose problems could be appropriately addressed by this service, particularly in its experimental form. One clinician commented upon the fact that the service “seemed like an extra add-on- needed to remember to use referrals- could be helpful to have some closer links so that made aware of all new admissions.”

The one clinician who was wholly negative about the service made many suggestions about the shortcoming of the project. He suggested that the roles were not explicit and that the patients themselves did not seem to understand my role. When asked if the service altered his perception of the person’s problems he said it did not and “it confused the situation out of the context of being an inpatient.” He felt that “the project makes more fundamentally biased assumptions that any institutional discrimination….‘Black mental health’ is a discriminatory term, and does not help an integrational organisation. The staff on the ward are from all cultures/religions and do not gain from an assumption that they are W.A.S.P.s.” This comment has been dealt with above.

One client said that the mediation service was helpful to him in that, “I could relate the things that I think are happening.” Another said it was helpful because she was able to “express my own opinion and discuss at length with the mediator.” Another client felt they benefited from the service because “I got my ideas across better.” The client who did not find the mediation service helpful said that being able to talk about her experiences were helpful. She suggested, “It was helpful to speak to someone who was outside of the in-patient hospital team and voice your feelings and hope these concerns would be referred to the physicians involved.” Her criticisms of the service were voiced in her evaluation form: “I don’t feel that the mediator had enough training to deal with the psychiatrist and readily believed the physician…..Imagine how I felt when I knew that the Dr. was lying and the mediator had been won over by the Dr.’s insincerity. Mediator needs more training in reading body language and not to be quite so trusting of the medical establishment. They are human and capable of lying and sometimes do.” In her comments she suggested there needs to be “a complete overhaul of the way mental health is practiced in the U.K. I don’t understand a system where the doctors don’t assess the patients, but rely only on observations of nurses and chance conversations.”

As mentioned previously, family members which were involved in the project also returned evaluation forms. All found the project helpful and felt it benefited their family members. They all said that they found being able to talk about their own experiences helpful. One mother suggested, “I liked to talk with you…when you talk you come to know things you didn’t know before.” And all three said they felt more satisfied with the care their family member received as a result of the help of the service.
Although the evaluations were positive, it does not detract from my experience during the project that the project suffered many obstructions. The evaluations also must not cloud the fact that I observed very little in the way of taking on board the approach of the project and any subsequent suggestions and information. The evaluations cannot be seen as entirely helpful in that they did not ring true with my experience. Success must also be measured in terms of how much of an impact the service had on patient care and in my view, very little impact was made. Thus, more attention needs to be paid to creating a better evaluation for future projects. Evaluation needs to occur over a longer period of time to assess whether clinicians are altering the way they are practicing and whether it improves client care and engagement. So although the clinicians may have found the service interesting and helpful, I would suggest that more needs to be done in order to effect change. Having said this, it will be important to create the next stage of the service in order to take advantage of the inroads this service made.

5. FACTORS IMPEding THE PROJECT

In the urban hospital, the organizational structure of the ward and professional control of care isolates the patient from family and community support networks. Indeed, the structure of the ward isolates the person from the entirety of their context and as this project was focused on this the organization itself impeded the project. The structure of the ward also interferes with rituals and activities that allow them comfort and a way for them to makes sense of their experiences. Furthermore, as Kaufert and O’Neill (1995) discovered with their observations of interpreters/mediators, there were extreme problems of interpreting the organizational structure of the hospitals for patients. The structure and function of large hospital is often difficult to understand. Like inmates in archetypical “total institutions” (Goffman 1961) patients must be socialized to fit into the hospital’s basic organizational structure. From the provider’s perspective, organizational rules and care regimens are justified on the basis of rationale emphasizing the ‘good of the institution’ or the need to ‘consider the rights of all patients and staff’ (Kaufert and O’Neill 1995:64).

A clear and consistent understanding of culture and the project itself was, at times, misunderstood. Clinicians, ward staff and the institution itself seemed to misunderstand the notion of culture. Culture was seen in terms of a set of practices and beliefs- it was reified. It would appear that culture was seen as something which could be set aside, as the clinicians focused on the medical concerns of the person’s problems. This approach is linked with the fact that the mediator observed clinicians focusing on disease and ignoring illness. Whereas the biological was central to the discussion, cultural and social concerns were set to one side. It was also found that ward staff and clinicians often thought that the mediator/ consultant would only be interested in working with people with “bizarre” ideas or practices. Culture was understood as being a set of rules which could be chosen and it seemed that there was not a clear understanding of
the fact that incorporating the clinician's (often medical) model was not a question of choice.

Psychiatry itself treats culture as a homogenous whole, so it is not surprising that there was a difficulty in seeing culture in the way that would have better facilitated this project. It is necessary to see culture as the lens through which people see the world, that it effects every aspect of the person. There is a problem with seeing culture as a homogeneous whole in the way it is treated in psychiatry. As Bourdieu explains, people themselves imbue and take on the culture in which they live. Culture is not a choice, but those taken for granted aspects. It is a reproductive system, says Bourdieu, which doesn't allow much room for change. Culture is embodied. Bourdieu suggests that whilst there are rules embedded within cultures, people act much more instinctively and act creatively within these boundaries.

Culture affects mental illness in several ways. Culture determines what is seen as normal and abnormal in a given society. Culture also determines how individuals or a group may account for and explain mental illness. Many cultures throughout the world, for example, take into account wider social and religious factors in explaining mental illness. This contrasts with the emphasis on psychological factors, biological factors, life events or stress which occurs in explanations in the West. Culture will also effect the presentation of mental illness (Dein 1997). As Dein continues to suggest, family structures differ markedly between cultures and this may effect mental illness. In some cultures management of mental illness may need to take into account wider kinship and family groups of which the client is a member. In many cultures, treatment aims to resolve tensions among family members of members of their social group. The complex and multi-faceted way culture effects mental illness and its treatment needs to be taken into account by clinical teams in order for a service such as this one to succeed.

Thus, the development of this project would benefit from an increased amount of preparation time both in regards to training staff and in regards to attaining an understanding of the features of the mental health organisation that will be relevant to the service under creation.

There was a certain amount of criticism about the fact that the project was focusing on black service users. Suprisingly, this criticism came almost exclusively from ward staff. In the evaluation form, one of the clinicians who was very critical of the mediation service said, “‘black mental health’ is a discriminatory term, and does not help an integrated organisation. The staff on the ward are from all cultures/religions and do not gain from an assumption that they are W.A.S.Ps.” Thus, the project itself received a level of hostility from some members of staff. It would seem that some individuals were trying to say that the issues were not about race, but they clearly are about race. We must
connect race and culture and both are political issues. It is necessary to speak of these issues and to link them with inequality and discrimination.

The above comments by the clinician reveal that some Trust staff did not see the need for a service which focused on black users. Indeed, a view was held from the outset that such a service could work for every service user, but that because of the present need with black service users, this pilot project focused on them. This project was not about white staff and black patients, it was clearly about understanding individual’s unique understanding of their illness experience and how that may differ from the people in charge of their care. This project and others like it must not be seen as an attempt to sideline services for ethnic minorities, but a necessary stage in a process that intends to create equality for disadvantaged service users.

As Fernando (1988) asserts, psychiatric research in Britain tends to ignore or marginalise social experiences of blacks and ethnic minorities. Research “based on these groups is perceived as being applicable to those groups alone, while research based on white people is incorporated into mainstream psychiatry as being applicable to everyone” (Fernando 1988:54). Thus, one must be careful in establishing special services for black people as long term solutions. The establishment of such services may be a useful short term, stepping stone to a more fair service for everyone. But we must be careful not to merely reinforce a racist model which sees black people as requiring an approach which would ‘educate’ them into white norms. (Fernando 1988). Similarly, we must not see issues such as ours as merely an anthropological issue.

As part of the initial stage of the project, contact was also made with service user groups and other community groups such as mediation services. Some expressed concern about the use of mediation, particularly because the mediator did not have formal mediation training. Other service user groups were extremely concerned about the fact that the mediator was not a black person and therefore could not empathise with their experiences. They also felt that medication was a major issue and felt that there was a problem as the mediator wouldn’t have the power to prevent medication from occurring.

Clinician support also came into question with the referral system. Cases which were referred by the clinician involved were more successful than those where the patient referred themselves or when the mediator approached the individual. This would suggest that such a service can be helpful if the clinician identifies a disagreement and room for improvement. By referring a patient that clinician is accepting that such conflict may be due to the person’s understanding not being taken into account. They are therefore willing to work with the service to improve the situation. It would appear that clinicians who refer patients are more willing to accept suggestions and input from such a service.
There is the very real question of whether negotiation is such situations is possible. By and large, it was the mediator’s experience that it was not. In most cases, the clinicians appeared unwilling to question their diagnoses and treatment plans. This seemed to be accentuated because all but two of the patients were sectioned and, thus, it was seen that the real issue was about containment and medication. Indeed, one clinician who was critical of the project said, the project “confused the situation out of the context of being an inpatient.”

A major problem which affected the service was the fact that the project received far fewer referrals than was hoped. As mentioned previously, much of the mediator’s time was spent going to wards looking for referrals and contacting clinical teams to remind them of the project. At the end of the project, there was a large increase of referrals, but with little time to intervene appropriately. Another problem in regards to referrals was the fact that it seemed that some referrals were inappropriate, in that the person’s concerns and disagreements could not be appropriately resolved by the service.
6. FINDINGS

Person in Context

The project found that there seems to be an inability to see people in their context. This is one of the major ways that an anthropological input can be valuable. Just as medical anthropology tries to see people in context to better understand their experience of illness, the clients the mediator was working with seemed to demand being seen in context. They seemed to constantly be battling against a reduction of their problems and experiences. A resisting of reification and the reduction of their experiences is particularly important as racism can be seen as reducing or reifying someone. The anthropologist sees familial and other social relationships as integral to the understanding of the individual. An anthropological approach can offer insight into the person in light of their family relationships, social relationships, and their interaction with their culture. Indeed, an anthropological approach stresses that the self is not bounded but develops and changes as a result of several factors. The consultant/mediator was able to meet with family members in their home environment in order to better understand the person in their own context. It is suggested that it is important to understand how the family sees the person’s behaviour. For example, in some cases the person’s behaviour may be seen as normative when seen in context of their social and family life.

At one point, the mediator suggested that a patient’s family seemed to share many of the person’s religious beliefs that they had felt were abnormal. He had expressed a concern about evil spirits. When his mother came in to take part in a ward round they mentioned that the patient had said that scars on his hands were caused by these spirits. The mother said that she didn’t know how such spirits could cause scars. The clinician responded, “so that is not part of your belief system.” In the mediator’s view, however, the woman was not denying a belief in these spirits, but simply did not understand how they could cause physical scars. Again, this seemed to be based on a wider misunderstanding, as the patient had said that his scars were caused by such evil spirits as evil people motivated by these spirits had knifed him.

There seemed to be a conflict between the narratives that the patients wished to give and those wanted by the clinicians. Thus, there was a conflict between the etic versus the emic narrative. The clients seemed frustrated because the clinicians and the other staff were not talking about what the patients wanted to talk about. The psychiatrists have a framework for the questions which they feel are important for assessment. Whereas the doctors were just interested in information for assessment, the patients saw the important points of their illness narrative to rest in other things. This situation added to the client’s feeling of not being heard. It is suggested that this is why clients were keen to speak to the mediator and were so grateful for the interaction. The mediator was seen as different from the other people in the mental health service with whom they had
come into contact in that the mediator listened and allowed them to talk about the things about which they wanted to talk. The open-endedness of the questions allowed the client to focus upon the things that they felt were central to their experience. It was the clients rather than the mediator who created the nature of the discussion. It was noticeable how grateful the clients were and how eager most of them were to talk about these things. Many of the clients commented upon the fact that they felt that the mediator was different in that she listened to them. It is suggested that contributing to ensuring that the person and their problems were seen in context was the main success of the project.

Racism

Another theme which seemed to predominate in discussions with service users was that of racism. Many of the individuals the mediator spoke to saw their present situation (experience of care) as arising out of racism and ongoing discrimination. Indeed, many saw their experiences with clinicians and other ward staff as part of this oppression. Many of the narratives emphasised that racism was a force against which they were constantly struggling. Whilst racism was acknowledged, it was not given a central focus by the clinical teams, and it did not seem to be talked about during meetings with the patients. Again, this can be seen as part of the overall trend of not seeing a person in their social context. Often, certain negative events on the ward were seen by patients in light of racism, yet there seemed to be little awareness of how such acts might be construed. For example, one patient complained to the mediator that his leave had been cancelled because of his behaviour, whereas a white woman who, in his opinion, behaved worse than him was still allowed her leave. He saw this clearly as an act of racism. It was explained to him during the ward round that this was not because of racism, but because the woman was known to the clinical team and he was not. Although the explanation made sense in the context of the ward, the patient continued to feel that he was being discriminated against.

There is the question of whether or not the mental health service is able to deal with racism and the patient’s experience of it. For many of the service users, the mediator worked with, the experience of racism and discrimination was central to their lives and their present situation. Yet there seemed to be no real discussion of these issues. It is suggested that to ignore clients discussion of racism is to deny their explanation of causation. Most of the individuals the mediator worked with saw their problems as being linked to and embedded within racism. Indeed, their experience of racism is part of their explanatory model and must be taken into account. This fact is even more relevant when, as was explained in the literature review, racism can be considered a stressor which is likely to cause more health problems.

In discussions about the possible causes of psychosis among the Afro-Caribbean population in England, the overall conclusion is that it cannot be solely explained
in genetic terms. Indeed, the contribution of environmental factors is ever expanding. Racism is one of the factors being investigated in studies looking at psychosocial and psychological hypotheses. Young and Ndegwa (in press) propose that the notion of racism can be seen as a form of chronic stress and that negative mental health outcomes, particularly psychosis, can be more than just an indirect consequence of such stress in the Afro-Caribbean population.

**Inferior Care and Unmet Needs**

Many service users complained that they felt that the clinicians did not spend time with them and could not possibly understand their point of view. Indeed, it was noticed that in general individuals were seen on very few occasions. One patient told the mediator that her doctors had actually never spoken with her and she was confused as to how they could have assessed her without speaking to her. She said, “I don’t understand a system where the doctor’s don’t assess the patients, but rely only on observations of nurses and chance conversations.” Ward rounds seemed to be the main venue for individuals to be seen by their doctors. Yet, many individuals found the ward round extremely unsatisfying and often frustrating. The mediator observed on several occasions that the ward round involved the doctors explaining their position to the individual. At the end of the session the person was allowed to speak, but if they wanted to speak for a long period of time, or became angry they were cut off and asked to leave.

In many of the cases, the mediator dealt with, the individual expressed the belief that some form of counselling would help them. Service users explained time and again that they wanted someone to talk to and that this was not happening on the ward. Many explained that nurses and other ward staff did not sit down and talk with them and give them any consistency of care. This can be seen as due to the fact that the nurses are so over-worked that focusing on sitting down with individuals may not be possible. The need for talking about their experiences sometimes made the mediator’s role confusing. Some felt that the process of talking to the mediator was therapeutic and although the mediator was happy to discuss their experience whenever they wanted to, the mediator had to maintain that she was not a counsellor and this was not her role. The mediator found that many patients found the mediation service helpful because of the fact that they were able to talk to someone on numerous occasions about their experiences.

On one ward in which the mediator was seeing two patients, the suggestion was made that one of the individuals thought that talking to someone might be beneficial. This individual had recently lost his father as well as other family members and explained that things had been distressing for him. When the mediator suggested this she was told that there is already a lot of ‘talk therapy’ on the wards as all the nurses are trained in this way. She was told that the patients get a lot of psychoeducation. This was surprising as the mediator was constantly told by present, and former service users, as well as staff members
that there simply was not any talk therapy and counselling available for patients. However, although the mediator felt that these suggestions were not taken into account, in the evaluation form, one of the clinicians on the team said that her suggestions had altered the treatment plan. A “psychotherapeutic approach may have been influenced, due to an increased awareness of cultural background,” stated the clinician.

In a number of cases there had been a death in the family within the past two years. In all cases the individual found the death extremely distressing and seemed to be a recurring theme in their narrative. Yet in all cases the bereavement was not addressed and the possible role in their distress and illness was not investigated. When the mediator spoke to one of the individual’s family they also explained his illness in terms of his father’s death. The whole family was finding it extremely difficult to cope with the loss of their father, but felt that it had effected this family member dramatically. They felt that he did not need to be in hospital and that his problem was psychological. The mediator found it surprising in this case and in others that unresolved bereavement was not seen as the main part of the person’s problems.

Insight

All our patients were described as lacking insight and most scored extremely low on the Birchwood Insight Scale. However, we have already discussed why the notion of insight is problematic in these cases. Such scales are also problematic as insight hinges on the person accepting that they have a mental illness, not any other problems. The mediator found that a patient who clearly felt there was something wrong with them, yet believed it to be something other than the medical model, voodoo; would score the same extremely low score on the insight scale as someone who maintained there was absolutely nothing wrong with them. It would seem that the insight scale was not valid for these people. This is not surprising in that insight itself is a western construct. Indeed, our measure of insight revealed that the concept of insight is extremely problematic and says far more about disagreement with psychiatric intervention and medication than it does about a person’s understanding of their illness.

As mentioned in the literature review, assessment of insight is “substantially a judgement of discrepancy between the perspective of a clinician and that of a patient” (McGorry and McConville 1999:132). Assessment is derived from the assessor’s perspective, even in Kleinman’s own work. Conflicts deriving from any number of elements of the “therapeutic process are often interpreted as a ‘lack of insight’ on the part of the patient rather than a relative divergence of views between clinician and patient” (McGorry and McConville 1999:132; see also Lazare 1989). As Johnson and Orrell (1995) assert, such elements can include a range of social and cultural factors.
Measurements of insight such as the model used by Greenfeld et al. (1989) could be largely affected by the patient’s ability to express their views on these complex and ambiguous issues (David et al., 1992). Thus, it is possible that these measures might indirectly measure IQ rather than insight (David et al., 1992). There is also the problem of circularity in these measures; “if questions regarding compliance are an integral part of an insight rating, it is invalid to use insight as a measure of (stated) compliance” (David et al., 1992: 599). It follows that the notion of insight is dependent upon shared notions of illness between clinician and patient and upon the ability of the patient to communicate their experience in an understandable way to the clinician. Thus, one can see insight as a form of control, a way of dismissing patients who resist the clinicians model for their illness and this is what we found in the project.

Many cultural groups see mental illness as highly stigmatising, thus, it can be seen that denying one is mentally ill may be a method of coping. There is some evidence that patients may protect themselves from the stigma of mental illness by denying that they are ill (Johnson and Orrell 1995; McGorry 1992; Lally 1989; Kennard 1979). Thus, it is possible that individuals deny that they are ill not as a result of the illness, but as a conscious attempt at protection. Loss of insight “could be seen as a way of coping where the patient finds the implications of a diagnosis of mental illness or the prospect of treatment very unacceptable” (Johnson and Orrell 1996:1084). This factor is particularly relevant for the African-Caribbean community who appear fearful of psychiatry and the treatments offered. Indeed, resisting labels and interpretations that have been applied to their illness may be important statements. Social life in this way is a "negotiation of meanings" (Marcus and Fisher 1986:26).

**Diagnosis**

The case of Allam reveals the fact that diagnosis itself can be a point of conflict. Indeed, in a number of cases the mediator worked with there was confusion surrounding diagnoses on the part of the clinical teams, patients, and patient’s families. Diagnoses seemed to change and sometimes there was little agreement about diagnoses when patients were transferred. Such finding parallel the literature which suggests that there is a large amount of disagreement in regards to diagnosis amongst psychiatrists. Indeed, “if psychiatrists disagree among themselves to this extent, even when they speak the same language and come from a very similar society, we may wonder what happens when they are trying to recognize problems in patients from a different society with a different native language” (p.116). The author goes on to suggest that differences in diagnosis may be due to the way doctors perceive patients. Littlewood suggests that twice as many black patients had had their diagnosis changed in the course of their psychiatric career, suggesting either that British doctors found it difficult to diagnose them or that the patients did not easily fit into the ‘classical’ categories. Such findings would support the observations of this project which saw conflicts
arising out of diagnoses and diagnoses changing during an individual’s time in care.

There are also some suggestions that ‘normal’ behaviours may be pathologised if they do not fit into the clinical team’s notion of normal. This does raise questions about who is deciding what is considered normal. The study reported by Skilbeck et al. (1994) which shows that black people who are ‘normal’ can be ascribed psychiatric disorders points to potential lines of enquiry in studies of diagnostic practice. In some cases the mediator found that culturally appropriate behaviour may have been seen as abnormal and labelled as part of an illness. Again, it would appear that behaviours and beliefs should be seen in their context in order to ascribe meaning to them.

There was also the suggestion that the service was inappropriate for some of the people being treated on the wards. It would appear that there may be cases of people receiving imperfect assessments and once an assessment is done it is difficult to undo. For example, some of the cases the mediator came across seemed to suggest depressive or anxiety-related problems, yet these seemed not to be acknowledged. It almost seemed that there were certain diagnoses available—schizophrenia, psychosis, drug-induced psychosis, and those who presented to the teams were labeled with these available diagnoses. There is the sense that the service cannot respond to people who may present with problems which fall out of these diagnoses. If, for example, a patient were sent to one of the wards, but were assessed as having clinical depression, would they be treated on the ward or would they be sent elsewhere?

Without knowledge of cultural beliefs and practices, doctors can easily fall prey to errors of diagnosis, resulting in inappropriate management and poor compliance (Dein 1997). A delusion, for example, is a false belief not amenable to reason and out of context with a person’s cultural and religious belief: diagnosing someone as deluded must take into account cultural and religious factors.

Explanatory Models

The issues that surrounded the mediation of explanatory models occurred on a variety of levels. On the one hand individuals often felt that their understanding of their problems were not taken into account. But similarly, it was often revealed that they did not know what was wrong with them— that they had not been told their diagnosis, or they felt that the clinical team had often changed their diagnosis. It is unclear whether this was simply the patient’s understanding or a reality, but what was revealed was that the patients and their families often felt kept in the dark about their illness. Similarly, the mediator found that when a diagnosis was explained, the patient and their family members often misunderstood the explanation. For example, there was the situation when the mother of a patient explained that she did not understand what schizophrenia was or how it worked. One of her sons had recently been admitted to hospital for
the first time and had been given a diagnosis of schizophrenia. Her other son had also been diagnosed with schizophrenia some years before by a clinical team at the same hospital. During the mediator’s interviews with her son and her, it became clear that they did not understand what schizophrenia was and that this illness had no meaning for them. They explained the problems in a different way. The mediator explained to the clinical team that this woman did not seem to understand the diagnosis. When the clinical team questioned her it became evident that she had thought that it meant “split personality” and it was apparent why she was resisting such a diagnosis for both of her sons. It was unclear if part of the mediator’s role was to explain the doctor’s model to the patient. It was clear that in many cases the patient had not been explained their illness and diagnosis. Yet the mediator did not feel that this was her role and in some cases felt that she shouldn’t get involved as the clinician may not have wanted to tell the person their diagnosis for a variety of reasons. Another patient’s mother explained to the mediator that she felt she did understand the diagnosis of schizophrenia, but only because she had seen two television programmes about the illness. These examples reveal that there are issues about communication and what the mediator observed was ineffectual or non-existent communication between clients and their clinicians.

There were problems which arose because of the focus on explanatory models. Indeed, the project came to be known as focusing on EMs, although much more was investigated. It became clear that there was not a full understanding of what explanatory models entail. In the preparation stage it would have been helpful to explore what the clinician’s conception of explanatory models were. Similarly, at the beginning of the project, it was thought that clients would have a relatively clear understanding of their own explanatory model. This was our assumption and, thus, became the project’s assumption. However, it became clear that people did not know about their own explanatory model, it is clearly not something that people think about. Although explanatory models are central for communication, people often don’t know their own explanatory models. This is particularly true of people who are mentally ill.

Explanatory models are fluid and changing and are negotiated and individual interpretations are modified through interaction with the models of other participants (Katon and Kleinman 1981). This is particularly relevant in our project where there was a patient and their models would be interacting with other patients, ward staff, clinicians, friends and family. Thus, explanatory models were in constant flux. Individuals may reject some aspects of other’s models and may incorporate other aspects.

The therapeutic process inevitably involves a dialogue, however imbalanced, between the two explanatory models. The patient’s explanatory model will be affected and shaped by the clinical encounter just as the practitioner’s model will be affected by that of the patient. However, in general, explanatory models are not shared nor negotiated in the clinical setting; often they conflict and have
negative therapeutic consequences. The doctor’s EM may be so different from the patient’s that the patient will misinterpret it. The doctor “almost certainly will fail to treat problems that are part of the patient’s EM, but not the medical EM” (Kleinman 1980:116). This will likely result in the patient rejecting treatment. Indeed, patient satisfaction in relation to treatment is bound to shared and negotiated explanatory models. As Callan and Littlewood (1998) illustrate, the most significant association with satisfaction was concordance between the patient’s and the psychiatrist’s explanatory model.

A study of how the EMs of patient and clinician interact offers a more precise analysis of the problems of clinical communication (Kleinman 1980) and this is what the project hoped to investigate. However, there did not appear to be much of an interaction between these models and what interaction there may have been was difficult to observe. The mediator observed very little consideration of the individual’s explanatory model. The interaction seemed to take on the process of trying to convince the patient of the etic perspective of their illness. Indeed, very little explanation of clinician’s explanatory model was given to the client. The interaction seemed to take the form of the clinician saying that the person was ill, the diagnosis was sometimes given and the patient would respond by denying the validity of the explanation. The explanatory model of the clinician did not seem to have meaning for the patient, furthermore, if it did have meaning the meaning was entirely negative.

There was the very real question about whether the main issue with these conflicts was differing explanatory models. In the two cases that were highly successful, it did seem to be primarily about explanatory models, although other issues did come into play. It seemed that many of the problems lay outside of the realm of explanatory models. In many ways it seemed to be about people being heard, given choices and feeling as though they had some control and some say in their treatment. During the project the mediator constantly questioned whether the focus should be on explanatory models. She discovered that it was a helpful starting point, but that there were so many other issues which also came into play complicating the situations. The one clinician who was very negative about the service suggested that, “Explanatory models are a very useful conceptual process to explain the interaction between culture and society. It fails when confronting individual conceptualisation which is experiential. Social pressures (i.e. housing, drugs etc) have a greater effect on the police/medical/sectioning than explanatory models in my setting. The subjective complaint (explanatory model) have an importance in social observation; the symptom manifestation is a clinical judgement in terms of diagnosis and cannot be explained within this illness behaviour. The explanatory model does not fit well within the realm of psychosis, compared to the research field (mainly somatic and depression reference).” It is suggested, however, that these issues are incorporated into explanatory models and that such a comment reveals a superficial idea of what an explanatory model is.
The above comment by the clinician suggests that political economy is not part of the equation of explanatory models. However, this is not the case. The approach of critical theory (Young 1982; Taussig 1980) “suggests that interpretations of events by participants and the meanings they assign to those events are structured by their historical participation in the social hierarchy” (Kaufert 1990). Explanatory models are a product of historical and ideological relations of economic and social inequality. It is important to note that people are not able to pick and choose their beliefs. Not only are they not able to choose, but the rejection or misunderstanding of clinician’s explanatory model may be embedded in other factors. Such a rejection may be integral to identity or other political issues. To black patients, diagnosis is a serious matter as it shapes the subsequent relationships between the black user and services, e.g. treatments given, justification of coercion, patronising of users and culture of low expectation which appear to be held by services, side effects of treatments tolerated by clinicians and disliked and feared by users.

The concept of explanatory model (Kleinman, Eisenbert and Good 1978) aids in concretising the disease-illness distinction for clinicians (Chrisman and Johnson 1986). Yet what the mediator saw was an almost total focus on disease and little consideration for illness. In many ways the lack of real interest in taking into consideration the client’s explanatory model revealed a complete focus on disease rather than illness. However, the project’s attempt to use EMs as a vehicle for improving clinician/patient communication in cross-cultural encounters was successful. But using EMs in this way should not need the participation of a third party. The clinician should be able to elicit EMs themselves and incorporate them into the therapeutic process. Co-participation in negotiation of shared decisions is ultimately dependent upon mediating between professional and client explanatory models, yet observations revealed very little emphasis on co-participation in the clinical encounter.

As mentioned previously, many non-western cultures view of illness is fundamentally in conflict with the perspective of psychiatry. Many cultures externalise personhood and illness causation. Obeah, witchcraft and the devil are common explanations for illness, distress and misfortune and such understanding places cause outside of the individual. Such beliefs seem to come close to persecutory ideas and paranoid delusions which are both common symptoms of pathology. Furthermore, black people in Britain often experience a paranoia which has a basis in reality or an external persecution. Indeed, “paranoia and persecution may coexist, and it is clear that persecution can induce paranoid phenomena. In the case of black people in Britain who have been shown anecdotally and statistically to suffer police harassment (Cashmore and McLaughlin 1991), the police, courts and other agent of ‘social control’ (including psychiatry) are the external persecutors” (Barker, in press:15). This author continues to suggest that writings on black identity reveals that there appears to be a significant similarity between the phenomenology of double
consciousness and the psychopathology of schizophrenia as defined by the medical hierarchy.

**Control and Constraint versus Care and Treatment: Differing Expectations**

Many of the patients the mediator met with were adamant that there was nothing wrong with them. They felt that they were doing fine and nothing was going wrong until they were taken against their will and brought into care. She found it difficult to work with them as a focus on explanatory models implies that the person acknowledges that something is happening to them. Although in some case it was possible to build and understanding of the way the person perceived what was happening to them, it was difficult to enter into any form of negotiation as it always returned to the fact that the clinical team thought they were ill, and ill enough to be sectioned; whilst the individual felt there was absolutely nothing wrong with them. While it is suggested that this sort of service may benefit these individuals, there may be other approaches that may be more applicable. The focus for these individuals was to prove that they were not ill and quickly became frustrated when they realised that the mediator could not discharge them or convince the clinicians to discharge them. Again, such situations point to the need to go beyond the individual. In situations like this it is necessary to bring in friends and relatives and ask them about their observations. Instead of putting the blame on the system, it would be beneficial to involve friends and family and use their opinions to discuss the illness with the client. The problem here lies with a system which focuses on the individual and whose bureaucracy prevents such interactions. The mediator observed on several occasions where the clinical team protected the family members by putting the burden of sectioning on themselves and the system when family members were expressing concern about their loved ones behaviour.

Having said this, however, there were cases where the individual did feel the service benefited them even though they maintained they were not ill. The service was able to get a fuller understanding of what had happened to bring them to the mental health service and to better understand their view. The mediator was also able to speak to family members to get their views. Such information could be given to the clinical team to broaden their understanding. Yet what these individuals wanted and the only conclusion which would satisfy them was a complete discharge and this was diametrically opposed to the clinical teams aims. The only possibility for agreement seemed to be collecting information to reveal whether or not the person’s behaviour and beliefs might be seen as explainable or normalised in light of their context. In some cases this was attempted, but it conflicted so dramatically with the clinician’s role of containment that discussion along these lines was impossible. In some cases it may have been appropriate to question diagnoses, yet the mediator simply did not have the authority to do so and clinicians did not welcome such suggestions.
By far the majority of the conflicts centred around the fact that the person did not feel that they needed to be in care and were angered by the fact that they were being held against their will. The care experience of minority groups within all specialist mental health setting is characterised by similar themes of care and control and professional neglect of mental health and social care needs (Sashidharan 2001). The findings of this project support this fact and add to the academic literature and service user testimonies which refer to excessive custodial care, including reliance on physical methods of treatment in preference to social or psychological interventions, use of higher than average doses of medication and medication aimed to control and contain behaviour rather than treat mental illness. Indeed, many of the cases the mediator dealt with seemed to highlight the problems with such experiences. The mediator found that many of the disagreements and dissatisfaction seemed to arise out of differences in expectations of the service users (and their families) and the mental health service. The family seemed to think that the individual would be getting treatment, specifically, that they would be getting some form of therapy and were frustrated when they found that this was not the case.

Whereas the focus seemed to be on control and constraint by the service, users and their families' expectations seemed to rest with treatment and cure. Indeed, there are underlying contradictions within most psychiatric practices between cure and control, and care and custody. The mediator found that in some situations the service was unable to respond to certain individuals as they fell out of the boundaries of control and constraint. It would seem that some individuals fall into a border-land where services are unable to respond to their needs. This issue came to the forefront with a client who contacted the service. She had admitted herself after a suicide attempt and had two subsequent attempts whilst on the ward which she explained were the result of being frustrated at not being listened to by staff. She and her friends were clear in their explanation that she was depressed and extremely distressed. They maintained that she could not go back to her flat because of the distress this would cause and had nowhere else to go. It became evident, however, that the ward was not the appropriate place for her, but no other option was provided and she was discharged after a few weeks which made her extremely angry and frustrated.

Sashidharan (2001) suggests that black and ethnic minority patients and their carers fare no better following discharge from in-patient facilities and during after-care. He suggests that there is evidence that “follow-up arrangements and after-care for minority groups are often inadequate and fail to address social and psychological needs with the treatment emphasis continuing to be placed on medication and supervision” (Sashidharan 2001:8). During this project the emphasis on mediation was apparent.

This project found, in line with the research, that black patients often enter the mental health service through a pathway of coercion which often involves the police. By far the majority of the service users involved in this project were
brought into care after the police were contacted. In some cases it was the
family members who contacted the police when they were concerned about their
loved one. It is suggested that the pathways into care need to be remedied. If a
person is brought into care against their will with the intervention of the police it is
already setting up an interaction of coercion, fear and force which is difficult to
alter. By this, it is meant that from the very outset the individual’s experience of
the mental health service is a negative one. There was the sense that things had
gone too far if the person had been brought into care by the police, was
sectioned, and was being given medication against their will. At this point it is
very difficult to get a person to engage and for them to see the mediator as
separate from the institution which, in their opinion, is treating them extremely
negatively. As Sashidharan (2001b) suggests, experience of psychiatry is
centred on these “social control” issues because it is here that the consequences
of discriminatory practice (Mental Health Act, custodial and compulsory care, use
of medication, lack of after-care) are most visible and where psychiatry seems to
operate in a similar way to the police or to the prisons” (p.247).

Religion

During the research it was observed that a negative professional attitude towards
religion seemed to be present. There seemed to be a conflict with the way
religious beliefs were approached by service users and the clinical teams
responsible for their care. All but two of the individuals with which the mediator
worked put their religious beliefs at the forefront of their discussions with her. In
some cases it seemed that the individual’s religious beliefs and/or behaviour was
cited as an aspect of their pathology. This attitude resonates with most
psychiatric texts which view religion as peripheral or even a pathological issue
(Neeleman and King 1993). Many users the mediator spoke to expressed the
feeling that many black people are religious and many see their experience in the
context of spirituality and religion. They complained that clinicians did not
acknowledge nor accept this aspect of their experience.

In one case the clinical team seemed to focus on the patient’s “religiosity” as a
major aspect of their pathology. The patient was told on several occasions that
the team felt this pointed to schizophrenia. These statements only increased the
individual’s feelings that they were not being listened to and not understood.
Such interaction also seems to increase the distance between the clinical team
and the patient and furthers the patient’s feelings of alienation. This was
particularly so in this case where the individual initially requested a Christian
psychiatrist who shared his culture as he felt they would better understand him.
This individual, however, was happy to discuss his beliefs with me, although the
mediator did not fit his requirements, as he felt that she would be tolerant and
interested in what he had to say about his belief system. It is suggested that it is
not a question of sharing religious beliefs, but in being tolerant about such beliefs
and not automatically seeing them in a negative light or part of a pathology.
The mediator had difficulty in trying to get clinical teams from seeing religious beliefs and behaviours in context. When she spoke to the above mentioned individual's family they were unconcerned about his religiosity and told her that they all were very religious. This information was passed on to the clinical team, but they maintained that from their understanding, the patient's beliefs did not resonate with his family and were abnormal. The mediator also felt that there was a general intolerance of religion. This same patient had a family friend, and pastor who requested to be allowed to pray on the ward with the patient, this request was denied. The reasons for this seemed to be that it would not be fair to other patients as they needed to control what happened on the ward. Another reason given was that they could not allow people who were not trained to work with mentally ill people to work with them on the ward. It was suggested that the chaplain be contacted, but the mediator suggested that this would not be acceptable by the patient as the pastor was a family friend and his specific brand of Christianity may not resonate with those of the chaplain.

The lack of sensitivity to the cultural forces of religion and spirituality reflects a general and powerful trend in psychiatry that has been discussed above, this being the ontological primacy that psychiatry assigns to biology over culture. The narrow focus on biological factors, combined with the “historical biases against religious and spiritual experiences, impedes culturally sensitive understanding and treatment of psychoreligious and psychospiritual problems. This is particularly apparent when ethnic minorities and non-western societies are considered.” (Lukoff et al. 1992:676). Again, we see the necessity of seeing a person in their context. When the cultural context of the individual is considered, some problems that present with unusual religious or spiritual content are, in fact, found to be free of psychopathology. During her time [Susie Kilshaw] working on this project the mediator found a rather negative and suspicious view of religion held by clinicians. This was in marked opposition with the service users who felt their religion was a major part of their life and had a role to play in their recovery. Indeed, religious beliefs were often referred to as part of the individual’s pathology. Having said this, once suggestions had been made to try to collaborate with religious leaders, many clinicians felt that it would be a helpful approach to do so.

One of the concerns expressed by clinicians was if the individual became religious or more religious recently. Clinicians pointed to a recent increase in religious conviction as pointing to pathology. Although such changes could clearly point to increasing distress, it is suggested that only seeing it in this light is problematic. It is not uncommon for people to use familiar, yet previously unaccessed belief systems to explain and cast meaning on their experiences. There seemed to be little interest in assessing in detail whether or not the individual’s religious beliefs were in keeping with their family’s beliefs. Although some clinicians were interested in seeing how the persons’ religious beliefs could be seen in context with their family members, in many ways the motivation
seemed to be to quickly point to the way the persons’ beliefs did not fit in exactly with those of their family.

From the data collected during this project, it would seem that religion was, in many cases viewed as pathological, problematic and harmful to the mentally ill individual. Viewing religion as harmful does not reflect recent research (Levin 1994; Craigie et al. 1990; Levin and Schiller 1987; Mathews et al. 1998). Many people rely on or reach for spiritual/religious faith when crises strike, particularly in times of serious mental illness. Religion as a coping mechanism has been shown to reduce anxiety and to assist in recovery from many types of mental illness and other conditions (Matthew et al. 1998; Park et al. 1990; Fallot 1998) nor does it allow for collaboration between physicians and clergy.

The mediator also observed on several occasions that the patient’s statements about religion were misunderstood or interpreted wrongly. For example, one clinical team seemed to focus on the fact that a patient has said that he felt protected by the bible. This was interpreted by the clinician as the person literally believing that the bible created a protective force-field around them. This issue was raised on several occasions by the clinician and the patient always corrected the clinician by saying that what he meant was that the words in the bible protected him. It seemed that the clinician did not understand such beliefs and was trying to make them seem more extreme. These notions were seen as bizarre by the clinician, which is surprising as they would be seen as very acceptable and mainstream by most Christians.

Neeleman and King (1993) also found that religious leaders were not generally considered as agencies to whom direct referral by doctors should be made. During this project, the mediator also found that religious leaders were not considered for referrals. Indeed, no real collaboration between religious leaders and clinicians was found. In fact, in one case, which has been mentioned above, when the patient requested their pastor the request was denied. When it was suggested that a person should be able to be in contact with their religious leader, the mediator was informed that the NHS pastor would be more appropriate. The mediator’s suggestions that this may not suit the person’s religious beliefs since Christianity had many different forms and associations were ignored.

The American Psychiatric Association has recognised the potential for conflicts between psychiatrist and patients with differing religious views and issued guidelines in 1990. These guidelines stressed that a psychiatrist should maintain respect for their patients’ beliefs. They suggest that “it is useful for clinicians to obtain information on the religious or ideological orientation and beliefs of their patients so that they may properly attend to them in the course of treatment” (1990). The guidelines state that “interpretations that concern a patient’s beliefs should be made in a context of empathic respect for their value and meaning to the patient”.

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Premature judgements rooted in a theoretical connection between religion and psychopathology fail to do justice to the multiple and diverse functions that religious and spiritual experience may play in the lives of consumers (see, for example, Sullivan 1993). As Fallott (1993) suggests, before arriving at a conclusion about a consumer’s religious or spiritual experience, clinicians need to make a careful assessment of the role of that experience in the consumer’s overall life structure and functioning.

Littlewood and Lipsedge (1981) used their Religious Interest Questionnaire to look at religious beliefs in Afro-Caribbean patients. They found that African-Caribbean migrants to Britain who were diagnosed as schizophrenic but who did not have the ‘first rank symptoms’ of schizophrenia had higher RIQ scores than those patients with ‘classic schizophrenic symptoms. The authors then argued that “idiosyncratic religious experience might be perceived medically as serious mental illness” (p.59). Thus, it can be seen that understanding the context of a person’s religious beliefs and those around them are central to appropriately assessing individuals. King (2001) suggest that taking a spiritual history should be a feature of the clinical interaction. Such a history would involve the process of gathering information from patients about their values, religious beliefs, belief in God, and whatever gives their life meaning. In the clinical context, such a history taking would also include questioning the individual about how their spiritual views affect their views on illness and health. Indeed, the mediator found that a major part of her work involved just this kind of information gathering.

As Fallott (1998) suggests, it is important to recognize that for many people with severe mental disorders, religious issues may be cause for distress but are not themselves expressions of mental illness. Lukoff, Lu and Turner (1995) emphasize the importance of understanding the person’s basic religious convictions and that of his or her religious community in order to assess psychopathology adequately.

In a seminar at the Maudsley by Archie Smith, a Professor of Pastoral Psychology, the focus was on Religion in Black families and incorporating such beliefs into care. Smith suggested that there are four overlapping circles which must be considered and held together. These aspects of a person’s care are: spirituality, religion, the community and the mental health service. He suggested that it was not uncommon for people to see religious meaning in every event—both in ordinary experiences and extraordinary experiences. Smith went on to suggest that this kind of experience has sometimes been misread by the mental health service. “the mystical and the mental health experience are very close—one must be careful when drawing the line.” One should not disconnect the medical side from the rest. Smith suggests that this approach would not be promoting the whole person and the health of the whole person.
The discussion of religion is even more appropriate given that this study focused on black clients. Research and findings from this project suggest that religion is highly influential to African-Caribbean people, including the importance of religiously encouraged support networks (Loewenthal 1995). The literature indicates a strong association between religion and various measures of physical and mental health. Religion provides social support for the phases of initial onset, prevention of relapse, and recovery. Religion also mitigates the effects of stress in that worship-related activities induce feelings of well-being and other beneficial social cognitive factors like identity and self-esteem.
7. FUTURE DEVELOPMENT OF THE PROJECT

Immediate Strategy

The project needs to have a further twelve months trial period so to increase its referrals of clients and develop the methodology. At the same time the project will concentrate on creating strong links with clinicians and other service providers.

We strongly advise that the project needs to expand in members so that the increase in client referrals can be dealt with. Furthermore, it will allow for the project staff to add to the objectivity of their findings by having a forum for discussion. The development of protocols for the long term implementation of the project findings should also be considered.

After the twelve-month trial period the project would benefit by undertaking a controlled trial where its philosophy and methodology could be implemented as policy in a number of clinical settings. This would then allow for and in-depth evaluation of the project.

Below are long term, training and policy recommendations that have emerged out of the project’s first twelve months.

Training

For such a service to be a success, there needs to be a focus on educating clinicians and other mental health workers about medical anthropology and how to properly use and benefit from such a service. Right from the beginning the institution and those who work within it must be primed for such a service. Preparation needs to begin on a meta level and include discussions about what is culture, racism, discrimination and inequality. Exploration is needed on what clinicians and other health care workers think about these issues. Such exploratory discussions must begin with a question of what is culture and move on to break down people’s misconceptions of these things. In line with the suggestion of the McPherson report, a project of this kind must start with learning more about ourselves- revealing that the “problems” are not about the patients, but contained within the institution itself. As the McPherson report suggests, we need to start with the failures of the mental health care system and move forward from this starting point.

Training for the workforce needs to be a priority to ensure the success of such a service. It is the professional interactions between individual mental health worker and the service user that will determine the adequacy and the quality of clinical care. Indeed, it is futile to develop a cultural interpretation/mediation/consultation service if the clinicians and ward staff do not understand how to use it and its relevance. Similarly, many conflicts may never occur if the mental health workforce is more competent, knowledgeable and have
a positive attitude to work with people from diverse cultural groups. It is suggested that the effort which has been devoted, in recent years, to increasing the ‘cultural awareness’ amongst health workers has not been fully understood or universally implemented.

Attention also needs to be paid to how to address and appropriately train people in regards to the issues of inequality and racism as the determinants of individual distress and the way mental health services respond to such distress. In the majority of the cases referred to our project, individuals expressed their distress and problems in the context of racism and discrimination. Most of the service users the mediator met with felt that they were being held against their will by a mental health service that was merely another discriminatory institution. Many individuals expressed their feeling that their present situation (their stay in hospital) was on a continuous line with their other experiences of racism. This is mentioned here to highlight the fact that black service users often frame their experiences of the mental health service in terms of racism. Thus, it is important that the service can respond to such understandings in an appropriate way. The ‘normalising’ and “corrective functions of psychiatry and the commonality of the service experience of minority ethnic groups and other socially disadvantaged groups within mental health services are usually glossed over in culture specific training resulting in the continuation of a depoliticised and, as a result, largely ineffective model of service intervention” (Sashidharan 2001:12). Thus, any scheme for training must take on board the themes from the current discourse around ‘critical psychiatry’ (Sashidharan 2001). The tendency to fall into the trap of the medicalisation of social problems and the distress arising out of them must be resisted. The discourse of medical anthropology can only promise to add valuable information and perspectives.

Although training is an important element to the success of projects such as these and in combating discrimination, it is unlikely that significant changes will come about simply out of cultural awareness training and a change in individual practices. To combat institutionalised racism successfully there needs to be a clear acceptance of the nature of the problem and a dedicated commitment to defeat racism. And part of this drive towards combating racism in psychiatry is to question the roots of it within the historical and cultural development of the discipline itself.

Developing a Cultural Consultation Service

It is suggested that such a service needs to involve individuals who would be experts in the medical culture of psychiatry who demands respect and authority from clinical colleagues. The same individual and/or others working within the service should have expert knowledge of the culture in question or possess the skills to investigate pertinent aspects of the individual’s cultural beliefs and background. Such a service would benefit from having a small team working collaboratively with a variety of skills and backgrounds. Having at least one black
researcher/team member would be a great benefit, particularly to work with individuals who feel more comfortable with a black interviewer. It has been brought to the mediator’s attention by service users and health workers that it would be more appropriate having a black person in the position she held. The main reasons for this suggestion were that a white person would not understand the experiences of racism, which is so integral to many of the service users experience and that individuals would feel more comfortable discussing such issues with a black individual.

A number of individuals constituting a team would also be able to provide support for one another which is integral to the success of such a demanding and often-attacked service. In the mediator’s view, cultural interpreters/mediators are in a difficult position, as they are often the subject of suspicion from clinicians and other ward staff as well as pressure from the service users they work with. Thus, it is extremely important that cultural interpreters feel supported within their role. Having a team of interpreters would also benefit such a service, as they would be able to discuss cases, provide input and together put forward suggestions. An integrated language and culture strategy in primary care is clearly indicated. Such a service could combine language interpretation services with cultural interpretation services, utilising team individual’s various knowledge, experience and skills. Thus, an individual who knows the service users language could be used as an interpreter, but could also provide information about cultural beliefs which may be relevant to the individual’s case. It may be difficult to develop such a specialised team on a small scale, thus, it may be more appropriate to develop a team who could be called upon to work across a larger number of boroughs. Such a service could be developed as a consultation service whereby NHS mental health hospitals across London could contact the service for help with a certain individual case.

As the project began to draw to a close the mediator became aware of a Cultural Consultation Service in Montreal. It is suggested that this would be a good model to develop a similar service in London. The CCS employs consultants from a wide range of backgrounds to help in assessing patients and providing cultural expertise. Consultants may include psychiatrists, psychologists, nurses, social workers, social scientists and lay people with special cultural and linguistic expertise. The consultation is not intended to be a replacement of care, but a supplement to mainstream care. The CCS service provides excellent methods and questionnaires that can be used in the continuation of this project.

A consultancy service can only work in wards that want such a service and one that is trained and prepared appropriately. Thought needs to be given to the complexity of setting up such a service and establish satisfactory rules and policy. Policies about appropriate interaction, safety and regular meeting would need to be established. For such a service to be a success there need to be clinicians who want to change and a consultation service that helps to facilitate this change.
Policy

There is need for mental health workers to adopt a more socially and politically informed role within the communities they serve. This is particularly important “for ethnic minority groups in this country whose perceptions about the nature and purpose of statutory services are problematic for both cultural and historic reasons” (Sashidharan 2001:5).

There is an increasing commitment amongst many mental health agencies towards providing ethnically or culturally sensitive services. However, as Sashidharan (2001) points out, “there is little clarity or uniformity in what is meant by culturally sensitive services, and the policies and service specifications aimed at achieving improvement in services remain obscure or poorly thought out. They are rarely implemented within the clinical arena of care itself. Despite this, cultural sensitivity and cultural competence in clinical practice remain the most popular themes in combating both individual and institutional thinking and practice” (p.8). The mediator found that the desire to construct and work with a more culturally competent practice varied from clinician to clinician and team to team. Indeed, it is suggested that there is a large variation which needs to be addressed to find a official approach and policy. It should not be left up to the individual clinician to decide whether or not they wish to work in these ways. The mental health service needs to work towards a unified approach to cultural sensitivity and clinical practice and then enforce it. Building cultural competency among health professionals involves more than just developing an awareness that culture is an issue in health, illness and health care. It is about developing the ability to recognise that others may view the world through different cultural lenses and about identifying and challenging one’s cultural assumptions, values and beliefs.

There is a need to adopt a more strategic approach in order to tackle effectively the racial and ethnic inequities that persist in contemporary mental health practice. Such a strategy needs to be well-thought out, wide in its scope and enforced. It needs to incorporate more and be farther reaching than “cultural competency”.

Although there already exists a mechanism to ensure that clinical practice including outcomes are systematically evaluated and discrepancies in service outcome addressed through audit and adoption of good practice, more needs to be done to ensure improvements. There is a necessity of a commitment at Board level, to external evaluation and the involvement of service users, carers and others from ethnic minority communities. Although projects such as this one are important, it is difficult for such a small project to lead to shifts in practice and policy. There needs to be more of a focus on a top-down approach where the commitment at Board level makes it imperative that learning from such projects is
incorporated within the practice and policy of clinical teams working with users of mental health services.
8. CONCLUSIONS

Initially, the project started along the lines of a mediation service whereby explanatory models were investigated and mediated. However, through the process of trial and error it became apparent that a different approach would be more successful. Thus, there was a deliberate methodological shift so that the project focused on gathering information, coming up with suggestions and passing on the products of the investigation. In this way the findings could add to the assessment and treatment of the individual. The conclusions of the first year suggested that working along the lines of an anthropological consultation or cultural consultation approach was more successful and produced more dramatic and positive results.

As well as continuing the project we also plan to expand in order to respond to the need to implement change on a large scale. We see the project as developing into employing a team, the cultural consultation team. Such a team would incorporate individuals with a variety of skills and backgrounds who would collaborate on cases. Expansion would also include training and policy making. This would involve the training of all staff as to how to appropriately and constructively use the service. We think that this project must become a regular and essential element of mental health service. Therefore, the expansion will include the creation of policy so that such steps become a standard process of patient assessment, diagnosis and care. Thus, understanding an individual’s problems within their cultural and social context will become standard practice and policy will be there to ensure that it is.

Race, ethnicity and racism are terms that are continuously used in the media and within political and academic debates and discourses. In general, they carry with them sensitive and negative images which make approaching them a difficult task. For this project to develop it must be seen as a positive service which can be used by clinicians, nurses and users so to make the process of understanding a more productive and positive task.

It has been made abundantly clear that black mental health service users by and large have a negative experience of care due to the inferior treatment provided. It has recently been reported that patients are now able to sue the NHS for wrongful detainment under the Human Rights Act (2000), the argument could also stand for black patients to sue NHS institutions for being institutionally racist\(^{12}\). This confirms that it is necessary to implement services which are seriously committed to changing black people’s care for the better. This service becomes a fundamental part of this restructuring of the overall approach to care from the level of the individual patient through to policy and reaching the very ethos of the mental health NHS service. This is why an innovative and positive service such as this is essential. The fact that patients and clinicians overall have found this project positive and helpful enhances the need for this service.

\(^{12}\) Especially with the introduction of the Race relations (Amendment) Act 2000
APPENDIX ONE

Kleinman’s Questions

1) What do you call your problem? What name does it have?
2) What do you think has caused your problem?
3) Why do you think it started when it did?
4) What does your sickness do to you? How does it work?
5) How severe is it? Will it have a short or a long course?
6) What do you fear most about your sickness?
7) What are the chief problems your sickness has caused for you?
8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?
APPENDIX TWO

Acknowledgments:

Roland Littlewood, Professor of Anthropology and Psychiatry, University College London.

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SIMBA.

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Amanda Van Eck, INFORM.

Debbie, Greenwich Network.

Hans Verrept & colleagues, Mediation project, Coordinatiecel Interculturele Bemiddeling, Belgium.
APPENDIX THREE

Client Detail Form.

HEALTH ACTION ZONE MEDIATION PROJECT

Client Details

Name: __________________________

Date of Birth: / / 

Male/Female

Marital Status: __________________________

Educational Level: __________________________

Employment Status: __________________________ FT / PT

When last worked? __________________________

Permanent/temporary? __________________________

What kind of work (skilled)? __________________________

Highest base job? __________________________

Housing Status: __________________________

Living alone? YES NO

With others? Who? __________________________

Living in Hostel? YES NO

Past History:

Separation from family? __________________________

Been in care? YES NO When? __________________________

Been in Prison? YES NO When? __________________________

Any Previous contact with criminal justice system? YES NO

If so, what was the nature of this contact? __________________________

Case Note Diagnosis: __________________________

Past Hospital Admissions: __________________________

length: __________________________

mode of entry into services: __________________________
Insight rating: 

Nature of the Disagreement?:

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APPENDIX FOUR

Patient Referral Form

HEALTH ACTION ZONE MEDIATION PROJECT
REFERRAL FORM

Please complete one of these forms for every patient you think would benefit from the mediation service, regardless of whether they agree to take part or not. We are interested in collecting data on all aspects of this service, including the numbers who were referred to this service but refused to take part. Once completed, please send to: Susie Kilshaw, Health Action Zone Mediation Service, Reay House, 108 Landor Road, London SW9 9NT

Date: __________________________________________

Name of Patient: ________________________________

Patient Contact Details: __________________________

Phone Number: ________________________________

Mobile: ________________________________

Name of Clinician: ______________________________

Case Note Diagnosis: ______________________________

Nature of Conflict : __________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Reaction of the offer to mediation service:

Was this referral discussed with the patient? : YES NO

Was the suggestion: ACCEPTED REJECTED

Notes: __________________________________________
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