

‘Can There Be Cultural Competence Without Culture?’

Psychologists’ Discourse on

Working with Minorities

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Preface

This research has grown out of a strong empirical interest in the recent emphasis on diversity and equality in mental health services. It is because of ongoing and broader concerns about the issues of migration and belonging, the problems with the notion of multiculturalism and community cohesion and the need to develop forms of practice which engages with minorities, their culture and inequalities, that the Department of Health Policy ‘Delivering Race Equality in Mental Health Care’ (2005) on the equality of services for black and minority ethnic communities, is relevant to debates on the use of cultural competence models in clinical psychology today. Set within this context this thesis is, by definition, an interdisciplinary endeavour that draws freely and eclectically on theories and findings from other subfields of psychology (cognitive psychology and social psychology), as well as other disciplinary fields (sociological studies and political philosophy), when these shed light on my data material or extended my analytical thinking. This interdisciplinary borrowing was necessary as there is little work in clinical psychology, to the best of my knowledge, which deals with these issues. This gap must be acknowledged, and there is no reason why the aspiring psychologist (researcher) should not learn from careful readings of many different disciplines. Whilst clinical psychological interest in the area of multiculturalism, equality and minority mental health may have been weak thus far, this research is premised on the conviction that there is a pressing need for psychological understanding in this area.

The material examined in what follows therefore reflects an attempt to cast a psychological eye over a wide variety of writings, and, so it is hoped, make a contribution to clinical psychological knowledge in this area.

It must also be noted that in accordance with the requirements of this Doctorate, the thesis is divided into three parts: a literature review; an empirical study; and, a critical reflection paper. While the literature review, of course, constituted the basis for the research question in the empirical part, they are presented as independent papers. The former two are also written for publication in the British Journal of Clinical Psychology, and the publishing guidelines adhered to are presented in Appendix A. The latter of the three papers is a critical and reflective commentary on the former two papers.

Abstract

The literature review in this thesis is an exploration of the recent emphasis in policy on the equality of mental health services for minority ethnic clients, with a focus on cultural competence models in clinical psychology. The review is based on a textual analysis of a policy document to consider whether cultural competence is a promotion or restriction of equality. The policy and models of cultural competence were found to employ essentialist definitions that could be an issue in developing appropriate and relevant services. It is argued that a context-specific and flexible interpretation of culture is required.

The empirical research examines clinical psychological discourses about working with minority ethnic clients. It discusses an interview study and a group discussion study conducted among clinical psychologists. Drawing on discourse analysis this research examines the interpretative repertoires and discursive strategies that psychologists use in their accounts of working with minority ethnic clients, and how these construct a particular version of cultural competence. In the interviews, an interpretative framework in terms of 'social context' involved a consideration of the client's cultural background, and an interpretative framework of 'individual context' was considered to be a way of formulating the client's own interpretation of cultural background. In the group discussion, the key interpretative framework was the 'individual/curious' repertoire, which also focused on understanding cultural background from the client's interpretation. It is shown that in using these repertoires the psychologists' construction of cultural competence oscillates between a risk of reifying minority ethnic groups and a risk of neglecting issues such as ethnic discrimination.

Based upon the literature and empirical parts, the reflective part of this thesis considers the researchers orientation to the research, in terms of epistemology, and as a minority ethnic researcher conducting research on the subject of minorities.

Delivering Race Equality in Mental Health Care:

A Reconciliatory Exercise

Purpose

This review is a theoretical exploration of the Department of Health policy ‘Delivering Race Equality in Mental Health Care’. The approach taken in the policy is to develop ‘community engagement’ between mental health services and minorities, and cultural competence in mental health professionals. The review has been undertaken to provide an overview of issues in community engagement and cultural competence that can be used for practice development.

Methods

The review has entailed an extensive mapping of literature, covering several areas relevant to equality and cultural competence in mental health, across various academic disciplines, and a textual analysis of the policy.

Results

The review demonstrates that overall there is a serious homogenising tendency in the policy and models of cultural competence, through the definitions and concepts applied to categorise minority ethnic groups. This is particularly indicated by the policy focus on ‘ethnic’ groups only, and a reification of ‘difference’ in cultural competence. The review describes the different factors and processes that lead to viewing minorities in ‘ethnic’ terms and how this overlooks identity and belonging as possibly variable, over time, interests, gender, values and perspectives.

Conclusions

The review emphasises the need for a context-specific and flexible interpretation of culture. Also, psychological views and research in the area suggests that there is no consensus as to what ‘cultural competence’ with minorities really means, or how it can be practiced. Finally, a variety of alternative concepts and approaches for revamping models of cultural competence and addressing inequality in mental health services are identified.

1 Introduction

This review is based on a textual analysis of the recent mental health policy Delivering Race Equality in Mental Health Care [DRE] (DoH, 2005), undertaken as part of doctoral study. The key question driving the review is whether the methods of achieving equality set out by DRE, specifically cultural competence, is a promotion or restriction of equality. Textual sources have been relatively neglected within qualitative research, which are potentially a rich source of data (Silverman, 1993). Murphy, Dingwall, Greatbach, Parker, & Watson (1998), point out that documents are a major feature of contemporary society and an important source of data. However, documents do not offer transparent representations of reality or ‘windows onto social phenomenon’ (Watson, 1997, p.84); rather they construct particular kinds of representations and they provide a unique version of reality. In the case of DRE, we are concerned with the way in which race equality in mental health care is characterised and how the material is put across (see Atkinson & Coffey, 1997; Hammersley & Atkinson, 1995; Scott, 1990; Silverman, 2001). This was achieved by undertaking a content analysis to explore the themes, issues and topics addressed by the policy, and an exploration of the language used in the policy and how it constructs information, such as minority identity, in particular ways (Aldrich, Zwi & Short, 2007; Iannantuono & Eyles, 1997; Silverman, 2001)

Textual analysis was used as the basis of this review because the policy provides a challenge, in its ambition to achieve race equality, to the ideas of multiculturalism that are currently circulating in the UK. It is a challenge, however, in a positive sense as it forces those of us who work in mental health services to rethink and broaden our

understanding of equality and diversity. Due to the significance of this challenge to all professionals, this review will attempt to highlight some of the theoretical and clinical issues that are particularly pertinent to clinical psychology. This introduction does not intend to recapitulate the entire review here; rather it will briefly foreground some of the key features.

The review highlights that minority ethnic groups generally experience mental health services in negative ways, which leads us to appreciate the significant contribution that DRE can make, through its plans to develop engagement with minority ethnic groups. However, the main criticism levelled at DRE is the over-reliance on essentialist ideas in its definition of ethnic communities and its inability to deal with heterogeneity and power relations. The categorisation of minority groups into *ethnic* communities ignores both the complexity of category relations/identities and individuals, particularly women, that interact within them. Specifically through the use of social psychological models and research, the possibility of multiple category relations is highlighted. While some classical social psychological models tended to overemphasise the binary aspect of category relations, and thus present minority categories as shaped by comparisons with a majority category, recent studies move away from the narrow dualism of minority/majority comparisons to a model focusing on complex intracategorisations. The introduction of structure and power into category relations provides space for an examination of institutional discrimination and institutional discourses and practices, including ideas of cultural competence. The problem of cultural competence models tended to be twofold: the esoteric focus on very specific cultural concepts, and the

abstract focus on very general cultural concepts. This review, however, does not argue for an abandonment of cultural competence models: it emphasises the search for universal values, such as human dignity arising from a human rights framework, for a more context-sensitive and flexible interpretation of experience.

2 Britain's Ethnic Minorities

The proportion of the British population that are of ethnic minority origin has doubled since 1975. And the ethnic minority population is more diverse now than it was then. According to the 2001 census, of the total population in Great Britain of 57.1 million; 50.4 million people are of white British origin while some 6.7 million have different ethnic origin (Quirk, 2006). Of the same total, 41 million are Christian, 8.6 million have no religion, 4.4 million did not state their religion, and the remaining 3.1 million people are comprised mainly of Muslims (1.6m), Hindus (0.6m), Sikhs (0.3m), Jews (0.3m) and Buddhists (0.1m). The relatively small size of the ethnic and religious minority populations in Great Britain and their greater tendency to cluster in small areas means that most regional areas are not particularly diverse. London is by far the most ethnically diverse region in Britain – it is home to more than three-quarters of Britain's total Black African population.

A glance at the ethnic composition of Britain reveals a picture of society as a mosaic of several bounded cultural groups, which are sealed off from one another (Narayan, 1998; Vertovec, 1996). The events of 11 September, 2001 in the United States, the Iraq war of 2003, the Madrid bombs of 11 March 2004, the London bombings of 7 July 2005, the

riots in the *banlieus* of Paris in January 2006, and the continuing Middle East crises, have shaped debates concerning multiculturalism in public policies (Groot & Payne, 2006). The debate is often seen as a clash between integration and assimilation. Integration supports the co-existence of minority cultures with the majority culture; assimilation requires the absorption of minority cultures into the majority culture (Sivanandan, 2006). Assimilation was something that Britain consciously rejected in favour of integration as far back as forty years ago. More recently however, the focus of assimilation in other European countries such as France, Denmark, the Netherlands and Germany, which are opposed to ethnic minorities having their own cultural expression, be it of dress (the veil), of language or of values, is increasingly influencing the approach taken in Britain (Ramadan, 2005a). For instance, Jack Straw's (Leader of the House of Commons) comments on the wearing of the veil by some British Muslim women (Edgar, 2006), resonates with the position taken in other European countries¹. Proposals for UK citizenship tests and for immigrants to learn the English language also follow the immigration policies and political discourses of other European countries. In the UK these policies relate to contemporary revival of national identity. On the television programme, *Newsnight*, in March 2005, Gordon Brown (Chancellor of the Exchequer) declared that we should focus on 'British values' to reshape integration and deal with fragmentation (see also Billig, Deacon, Downey, Richardson, & Golding, 2006). The challenge for multiculturalism is getting the balance right between allowing every group

¹ There is a ban on wearing the veil in Holland, and in the public arena in Turkey, as well as in the schools of France. In Germany, there is a call to ban civil servants from wearing the veil, and in Sweden the new integration and equality minister 'Nyamko Sabuni' wants to ban the veil being worn by girls under the age of consent, which is 15 in Sweden (Powell, 2006).

its own distinct identity and, at the same time, seeking an integrated Britishness we all share (Freedland, 2006; Phillips, 2006; Ramadan, 2005b).

This is a theme that plays a central role in the new Commission for Equality and Human Rights (CEHR)², which has prompted new statutory activity in the form of the Equality Act (2006). Together with the Race Relations Amendment Act (2000) this legal shift no longer only makes it unlawful for public authorities to discriminate in any of their functions, but imposes positive obligations on such authorities to promote race equality (Bindman, 2006; Fredman, 2001). In this context, the Department of Health has taken a more pragmatic line: it advocated partnership with disadvantaged communities in order to ensure appropriateness and accessibility of services (Department of Health, 1999; Social Exclusion Unit, 2002). This development was continued in mental health services also and was clearly articulated in the policy Delivering Race Equality in Mental Health Care (DRE, DoH, 2005). This review concentrates on this policy, because it can be read as part of the challenges and questions that diversity poses insofar as it attempts to address the significance of institutional discrimination to the inequalities experienced by minority mental health service users. It is perhaps appropriate, however, to start with an exploration of why DRE has been concerned with partnership with minority ethnic communities in mental health services, turning to the experiences of minority ethnic groups in mental health services.

² The commission will replace and combine the Commission for Racial Equality, the Equal Opportunities Commission, and the Disability Rights Commission. The CEHR elevates anti-discrimination law to a constitutional level in line with The European Human Rights Convention and the European Charter of Rights.

3 Minority Groups and Mental Health Services

3.1 Prevalence and epidemiology

Research evidence suggests that there are important and possibly large differences in mental health across ethnic groups (O'Connor & Nazroo, 2002). The Count Me In census provides, for the first time in 2005, information about the ethnicity of inpatients in mental health institutions in England and Wales³. The purpose of the census is to help mental health services ensure that services are culturally appropriate, and provide improved information on service delivery. The census has shown that rates of admission to hospital were three or more times higher than average for men from Black groups⁴. Black service users were also more likely to be referred by the court (than their GP); admitted under the Mental Health Act 1983; and once in hospital, more likely to experience seclusion, physical restraint and to be on a medium or high secure ward.

These findings are not new. The statistical existence of inequalities in diagnosis and treatment of African-Caribbeans in the UK is well established (Aspinall & Jacobson, 2004; Bhugra, Harding & Lippett, 2004; Bhui et al. 2003; Bhui, Christie & Bhugra, 1995; Boast & Chesterman, 1995; Davies, Thornicroft, Leese, Higginbotham, & Phelan, 1996; Dunn & Fahy, 1990; Harrison, Owens, Holton, Nelson, & Boot, 1988; Littlewood, 1986; Littlewood & Lipsedge, 1981; Lloyd & Moodley, 1992; McGovern & Cope, 1991; Singh, Croudace, Beck, & Harrison, 1997). The less effective routes in and taken through

³ Results of Count Me In 2006 are due to be published in 2007. The 2005 census was organised by the Healthcare Commission, the Mental Health Act Commission and the National Institute for Mental Health in England. Information was collected from 33,828 inpatients. Overall, 79% of inpatients were White British and 19% were from BME groups, 9% from BME groups were Black Caribbean, Black African, Other Black, 3% were from Other White, 3% were Asian, 2% were Irish, and 3% were from other ethnic groups (including Chinese).

⁴ Black African, Black Caribbean, and Other Black.

psychiatric services are also well documented (Audini & Lelliot, 2002; Bhui, Bhugra, & Goldberg, 2000; Burnett & Mallet, 1999; Churchill, Wall, Hotopf, Buchanan & Wessely, 2000; Commander, Cochrane, Sashidharan, Akilu, & Wildsmith, 1999; Fernando Ndegwa, & Wilson, 1998; Gupta, 1991; Moodley & Perkins, 1991). The stereotyping of Black service users as ‘dangerous’ can be seen as a feature of the seclusion and restraints exercised by services (Barnes & Bowl, 2001; Laurance, 2002; Link & Phelan, 1999; Prins, Backer-Holst, Francis, & Keitch 1993). The limited referrals to talking therapies and greater use of bio-medical treatments can be seen as another feature of the constraints experienced (Bondi & Burman, 2001; Callan & Littlewood, 1998; Chantler, 2005; Kearney, 1996; Lago & Thompson, 1996; Penfold & Walker, 1984; Pilgrim, 1997).

It is important to note, however, that findings are not consistent across different studies (Iley & Nazroo, 2001), and there have been few community based studies of ethnic differences in the prevalence of mental illness, with most work focusing on rates of contact with services for those with psychotic disorders (Bhugra et al. 1997; Harrison, Amin, Singh, Croudace & Jones, 1999; Harrison, Owens, Holton, Neilson & Boot, 1988; King, Coker, Leavey, Hoare, Johnson-Sabine, 1994). A valuable exception is the study of *Ethnic Minority Psychiatric Illness in the Community* (EMPIRIC)⁵ (O’Connor & Nazroo, 2002). The principle authors of this study point out that the research tools used in epidemiological surveys, which are based on Western psychiatric practice, may be more appropriate for some ethnic groups than others (O’Connor & Nazroo, 2002). They argue that the quantitative epidemiological method ignores social context and experiences

⁵ Carried out on behalf of the Department of Health by the National Centre for Social Research (UK) and the Department of Epidemiology and Public Health at the Royal Free and University College Medical School.

of people as lived rather as constructed by diagnostic categories (Fenton & Charsley, 2000; Popay, Williams, Thomas & Gartrell, 1998). Central to this view has been the claim that the idioms used to express mental distress, the ways in which people describe their feelings and their understanding of mental health, vary across different ethnic groups (Jadhav, 1996; Kleinman, 1987). The implication is that standardised research instruments will perform inconsistently across different ethnic groups, greatly restricting the validity of conclusions based on their use in surveys, which needs to be addressed by both research and practice (Sproston & Nazroo, 2002).

The EMPIRIC study consisted of two elements, a quantitative survey of rates of mental illness among different ethnic groups in England (Sproston & Nazroo, 2002) and a qualitative study investigating ethnic and cultural differences (O'Connor & Nazroo, 2002). This review will mainly focus on the qualitative part of the EMPIRIC study, which was concerned with understanding how the context of respondent's lives shapes their experiences of mental distress and mental health services, which can further develop our understanding of the factors and experiences underlying the quantitative patterning of mental health. The qualitative study is based on interviews from a sub-sample of respondents to the quantitative survey, which was drawn from the existing 1999 Health Survey for England (HSE)⁶ (Erens, Primatesta & Prior, 2001). One hundred and sixteen people, from the Bangladeshi, Caribbean, Indian, Irish and White ethnic communities, participated in the qualitative study.

⁶ The HSE comprises a series of annual surveys commissioned by the Department of Health and designed to provide information on aspects of the population's health that cannot be obtained from other sources.

Respondents were purposively selected on the basis of their experience of mental distress, as determined by quantitative and qualitative information of their experience of common mental health disorders. This paper reviews findings that focus on the variations in the language used to describe emotions and experiences, and what this can tell us about whether western assessments and concepts of mental illness adequately capture the experience of mental distress across different ethnic groups. References to other studies are also included where they enhance understanding of the EMPIRIC findings.

3.2 Explaining the cause of mental distress

An early contribution to the exploration, by qualitative methods, of meanings of health and illness among minority patients and communities in Britain, was Curren and Stacey's (1986) analysis exploring concepts of mental health and illness among Pathan mothers in Britain. Other work has looked at the extent to which lay views of health and illness causation coincided with medical scientific views: for example, Blaxter's, (1983) work with women in Aberdeen, and Krause's (1989) exploration of the ways in which Punjabis in Britain describe and explain their illness. This literature has established the importance of taking on board individual views of health and illness, in order to overcome stereotypical generalisations, for example that certain groups have no real understanding of mental illness.

Participants in the EMPIRIC study generally understood the idea of 'cause' in terms of: difficulties within families and personal relationships; experience of racism; employment and financial difficulties; and poor physical health (O'Connor & Nazroo, 2002). The

broad areas occurred across all the cases, regardless of ethnic or gender group or likelihood of mental health difficulties. However, one particular distinction was that whilst family difficulties occurred in all the different groups, in South Asian communities it appeared to be linked also to a sense of community reputation (i.e. anxiety about the reputation of the family within the community). There were also some particular problems associated with divorce and separation that were concentrated among White and Black Caribbean groups and problems with being in arranged marriages that were concentrated among people in South Asian groups (O'Connor & Nazroo, 2002).

There were also subtle differences in the way these different experiences affected mental health. Racism, for example, was described as producing feelings of fear and tiredness, while financial difficulties were associated with a loss of self-respect. Therefore there were differences in how people talked about themselves and their mental health, which suggests that while mental health professionals may find that these broad issues underlie anxieties and depressions across different ethnic groups, they will also vary in nature from case to case (O'Connor & Nazroo, 2002).

3.3 Idioms of mental distress

A key concern of studies of ethnic differences in mental illness is whether the idioms used to express mental distress are culturally informed. This is particularly important in understanding the prevalence of mental illness among South Asians. Whilst some studies suggest that the prevalence of mental illness among South Asians is lower than that for the general population (Cochrane & Bal, 1989; Cochrane & Stopes-Roe, 1981; Gilliam,

Jarman, White & Law, 1989), other studies suggest that these lower detected rates could reflect language and communication difficulties, rather than a genuinely lower prevalence of mental illness (Krause, 1989).

It has also been suggested that some groups may experience particular ‘culture-bound’ syndromes, that is a cluster of symptoms that is restricted to a particular culture, such as ‘sinking heart’ described by Punjabi people (Krause, 1989). Or some may be more likely to somatise mental illness, that is experience and describe psychological distress more in terms of physical symptoms (Rack, 1982), which are less likely to be identified as mental illness in both epidemiological research and clinical practice. For example, Williams, Eley, Hunt and Bhatt (1997) found that a standardised western assessment of psychological distress under-estimates problems among South Asian people living in Glasgow relative to their white peers when compared with self-reports of distress, or a measure that more directly assessed somatic symptoms.

The findings from the EMPIRIC study appear to offer a mixed picture in relation to the above findings. Firstly, whilst emotional experiences of distress appeared to be broadly universal across ethnic groups, rather than culturally specific, some diagnostically important experiences (loss of confidence, guilt and shame) seemed less prominent in the accounts of Bangladeshi respondents and, in some cases, other respondents in South Asian groups who were not interviewed in English (O’Connor & Nazroo, 2002). Secondly, whilst physical symptoms and idioms were common across all groups, they appeared to be more richly described by respondents in South Asian groups, particularly

those who were migrants and interviewed in languages other than English (O'Connor & Nazroo, 2002). The EMPIRIC study, therefore, gives no support to claims that there is widespread misunderstanding of the category 'mental health' among ethnic minority groups (Nazroo, 1998; Ineichen, 1990) and that Asian patients, rather than others, somatise. However, respondents also had an elaborate language for describing mental and emotional symptoms and some specific symptoms did not appear to be universal across ethnic groups. This suggests that a structured survey instrument might not be culturally neutral and may have a poorer fit for the experiences of some ethnic minority groups, particularly non-English speaking people in South Asian group. The additional implication is that an itemised approach to diagnosis may fail to adequately capture experiences of mental distress (O'Connor & Nazroo, 2002).

Professionals can gain access to emic perspectives of mental health by using culturally neutral tools such as the 'Short Explanatory Model Interview (SEMI) (Lloyd et al. 1998). The SEMI aims to elicit the respondent's cultural background and beliefs related to mental illness. It is designed to encourage respondents to talk openly about their perceptions and experiences, by avoiding the use of any medical or technical language. Lloyd et al. (1998) employed the SEMI with three ethnic groups in the UK, Whites, African-Caribbean and Asians, and with people from Zimbabwe, to explore variations in cultural perspectives of illness and its treatment. For example, British Asians were found to expect tablets or injections, and the expectation of learning the diagnosis and of receiving explanation and advice was higher among the White British group (Lloyd et al. 1998). The elicitation of the client's model could help the process of psychological

assessment and formulation, by enabling the psychologist to understand the client and help the client make sense of their experience.

3.4 Coping mechanisms

Findings from the EMPIRIC quantitative data suggested that psychiatric morbidity was related, in part, to an individual's coping mechanisms and their level of social support (Sproston & Nazroo, 2002). The EMPIRIC qualitative study found that religious resources were important coping mechanisms for certain ethnic groups (O'Connor & Nazroo, 2002). There is now a greater recognition of the close link between religious practice, religious coping and mental distress (Copsey, 1997). Religious practice usually involves a social network within which people meet and pray together regularly and social networks, in turn, are known to protect, against the development of mental distress, and aid in recovery (Cohen, 1988).

In the EMPIRIC qualitative study religious ways of coping appeared to play the greatest role in the lives of Black Caribbean and South Asian respondents who relied most on their beliefs in times of difficulty (O'Connor & Nazroo, 2002). This lends support to the finding that South Asian women use prayer as a major coping strategy in the face of depression (Beliappa, 1991). Professionals, therefore, need to be familiar with religious and spiritual aspects of distress (Sims, 1994). For example, a recent study showed that South Asian mental health services users complained that their religious ideas were not always considered in their treatment and felt if they had been their care would have been better (Bhui, Chandran & Sathyamoorthy, 2002). The aim should be to ensure that

religious issues are considered in the development of mental health services (NAHAT, 1996).

3.5 Use of services

The EMPIRIC study looked at participants' use of and satisfaction with external services (GP, psychiatric care, counselling and therapeutic services). A key finding was centrality of language in determining accessibility of services. It was found that GP consultations not conducted in the patient's first language appeared to reduce the patient's ability to fully explain their situation, or request a referral to a secondary service, lending support to the view that GPs are possible gate-keepers to secondary services (Goldberg & Huxley, 1980; Hussain, 2006; Lloyd & Fuller, 2002; Murray et al. 2006).

The inaccessibility of services based on language may be one explanation for the EMPIRIC quantitative survey finding that access to counsellors or psychologists was highest among the White, Irish and Black Caribbean groups (Sproston & Nazroo, 2002), in spite of the higher rates of GP consultations among South Asians, relative to those of Caribbean origin (Balarajan, Yuen & Raleigh, 1989; Gillam, Jarman, White & Law, 1989; O'Connor & Nazroo, 2002). However, Williams and Turpin (2006) describe several methodological problems with the earlier studies of GP attendance rates. Firstly, they tended to lack specificity with regards to definitions of ethnicity (due to the absence of standardised criteria prior to the 1991 census) and often utilised diagnostic tools for the classification of mental illness that were not normed on minority ethnic groups (Marsella & Kameoka, 1989). There was also a tendency to routinely use practice attendance rates

for White ethnic groups as a standard benchmark in which to make comparisons with the other ethnic groups (Bhui, 1999), and they frequently failed to report on the outcome of these consultations for the different minority ethnic groups (Marsella & Kameoka, 1989), especially in relation to psychological and other related problems (Erns, Primatesta & Prior, 2001; Shaw, Creed, Tomenson, Riste & Cruickshank, 1999).

Despite the relatively high GP attendance rates of South Asians, their referral to clinical psychology services still remain relatively small (Fatimilehin & Nadirshaw, 1994; Fernando, 1991; Nadirshaw, 1992; Patel et al., 2000; Webb-Johnson & Nadirshaw, 1993). Apart from the issue of language, a key factor might be racial stereotyping and the discrimination that results when services fail to meet the cultural needs of minority ethnic groups (Bhui, 2003; Sainsbury Centre for Mental Health, 2002). For example, in psychological literature 'Asians' have been described as being 'psychologically robust', thereby suggesting that psychological services are not applicable to members of these groups (Beliappa, 1991; Nadirshaw, 1992; Webb-Johnson & Nadirshaw, 1993). At the same time, it has been suggested that even if psychology services were offered more routinely to minority ethnic communities and in an accessible manner this may not increase service uptake, because of a lack of consideration to other culturally relevant factors (Beliappa, 1991; Nadirshaw, 1992; Sainsbury Centre for Mental Health, 2002). Factors that need to be addressed are the assumptions about the religious and cultural values and practices of different ethnic groups (Nadirshaw, 1992), the failure to recognise individual differences within cultural groups and the practice of making inappropriate comparisons with norms in the British culture, as a standard against which other cultures

may be judged (Webb-Johnson & Nadirshaw, 1993). Without addressing these areas the fears amongst minority ethnic clients that their distress may be misconstrued and/or pathologised are likely to remain (Owusu-Bempah & Howitt, 2000; Sainsbury Centre for Mental Health, 2002; Sproston & Nazroo, 2002). For the psychologist, there is also the challenge to identify the assumptions and norms that underpin the process of assessment, formulation and treatment (Eleftheriadou, 1994; Fatimilehin, 1989).

There are, therefore, a number of factors which influence service use: the service user's own (cultural) perceptions of their distress; the accessibility of services; and service users' expectations of the approach adopted by professionals. These are factors that would need to be taken into account in addressing inequalities in mental health services.

3.6 Social exclusion, socio-economic factors and mental health

The implications of social exclusion to the understanding of mental health inequalities have been emphasised (McClean, Campbell & Cornish, 2003; Nazroo, 1997; NHS Executive Mental Health Task Force, 1992; Smaje & Le Grand, 1997; Wilson, 1993).

The proposition that lower socio-economic status and lower quality of the local social environment is related to poorer mental health (Addington, van Mastricht & Addington, 2004; Adolescent Health BMA, 2003; Clarke *et al.*, 1999; Dalgard & Tambs, 1997; Kelly, 2005; Mulvany *et al.* 2001), suggests that exploration of the implications of most minority communities living in the most deprived neighbourhoods of the UK (Social Exclusion Unit, 2002), as well as the disproportionate location of African-Caribbean people in lower income groups (Modood *et al.* 1997), should be areas of investigation in

the study of the relatively poor mental health experienced by African-Caribbean community members (Morgan et al. 2005a, 2005b). For example, data from the Fourth National Survey of Ethnic Minorities⁷ showed that differences in material standard of living made at least some contribution to higher rates of depression and psychosis among Caribbeans compared with White respondents (Nazroo, 1997). However, other studies have reported no differences between African Caribbean and white groups (Shaw, Creed, Tomenson, Riste & Cruickshank, 1999).

3.7 Cultural exclusion and mental health

Exclusion is also suggested to occur in the dominance of Western mental health terms and concepts, over minority mental health terms and concepts (Campling, 1989; Odell, Commander, Sashidharan & Surtees 1997; Sashidharan & Commander, 1993). The dominance of Western views may be seen to be part of the institutional disadvantage and discrimination that minorities experience in a variety of different contexts (Clark *et al.*, 1999; Fernando *et al.*, 1988; Goldberg & Hodes, 1992; Karlsen & Nazroo, 2002; McKenzie, 2003; Mclean *et al.*, 2003; MIND, 1988; Wilkinson, 1996). For example, the discursive hierarchy may suggest to minorities that their views will not be considered or that discrimination has not been tackled. It has been argued that Western models of mental health are 'Eurocentric' and therefore limited as a conceptual framework for use with minority ethnic service users (Alladin, 1993; Lago & Thompson, 1996; Webb-Johnson & Nadirshaw, Patel et al., 2000).

⁷ Conducted between 1993 and 1994 by the Policy Institute and Social and Community Planning Research, explored the experiences of ethnic minority people living in England and Wales, and covered mental health, physical health and a range of socio-economic and demographic variables.

Whilst there are alternative models that take on board the dynamics of racism and the wider social context (e.g. Alladin, 1993; Eleftheriadou, 1994; Kareem & Littlewood, 2000; Webb-Johnson & Nadirshaw, 1993), these approaches are predominantly used in specialist organisations (e.g. Roach, 1992) and are thus not fully integrated into mainstream services. Mainstream services need to find ways of integrating the views and frameworks of minorities.

We may argue then that DRE's attempt at developing a partnership with minority communities is of considerable significance (Bhui, 2001; Bhui et al. 1995; Jennings, 1996; Keating & Robertson, 2004; Mclean et al. 2003; Parkman, Davies, Leese, Phelan, & Thornicroft 1997; Roach, 1992; Young Minds, 2005). In what follows, however, it will be argued that amidst the propositions to partnership are a host of challenges, which include the complexities and heterogeneity of ethnic minorities and the use of essentialist notions to define ethnic communities. This review focuses on the possible implications of these notions in policies and the way they might be related to clinical psychological practice. The central argument is that essentialist representations of ethnic communities can be used in various ways and with various effects. Essentialism can be a useful tool for minorities who can put forward claims, such as cultural rights, in terms of their 'authentic' culture. Essentialism can also be a powerful tool for the majority, as essentialist beliefs or stereotypes about minorities serve to maintain existing social arrangements. These positions will be examined in terms of whether cultural competence models are effective in providing minority ethnic service users a mental health service which is sensitive to their cultural beliefs and can understand them.

4 A Brief Overview of the Policy Delivering Race Equality

The main goal of DRE is to support mental health services' ability to respond to minority needs through advocating and setting up new community engagement models. The policy has three strands: more appropriate and responsive services, community engagement, and better information, which includes the census of mental health patients previously described. The policy was launched in 2005, but builds on key previous publications⁸ that were responsible for gaining the views held among minority ethnic communities, as well as presenting the findings of the inquiry into the death of David Bennett (a 38-year-old African-Caribbean service user who died in 1998 in a medium secure psychiatric unit after being restrained by staff). The Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death form the backdrop to DRE's programme for achieving equality. The report of the inquiry into the death of David Bennett highlights the impact and significance of institutional discrimination in mental health services, which DRE essentially corroborates the validity of, whilst only, and importantly, giving it 'contextual accommodation' leaving how to address it unaccounted for. Inclusion of minority ethnic communities therefore connotes a degree of one-dimensionality that does not stand up to achieving equality. In due course it will be argued that the inclusion of ethnic communities as articulated by DRE is problematic without an analysis of the role of the institutions; for the time being, however, the discussion is concerned with the definition of ethnic community used by DRE, which contains a number of complexities that make inclusion not so straight-forward.

⁸Inside Outside: improving Mental Health Services for Black and Minority Ethnic Communities in England (DoH, 2004); Delivering Race Equality: A framework for Action (DoH, 2003); and the Independent Inquiry into the Death of David Bennett (2003).

5 Ethnic Categorisation: Minority/Majority Relations

Malik (2006, 2007) draws attention to a crucial issue that forms part of the wider context to DRE: the fact that partnership with ethnic minority communities, for the purposes of providing them with social recognition and an equal distribution of resources, requires the categorisation of minority groups into ethnic groups, inevitably creates divisions and tensions between groups. Malik's (2006, 2007) view is based on the observation of the riots in 1985 in Handsworth (Birmingham), when Blacks, Whites and Asians were in a common struggle against oppressive policing. In response to the riots the Birmingham council created nine 'umbrella groups' based on ethnicity and faith, the function of which were to represent the needs of specific communities. Malik (2006, 2007) discusses how social recognition and the allocation of resources based on ethnic categories can make people susceptible to identify themselves solely in terms of those ethnicities and to identify others as also belonging to particular ethnic groups. Malik (2006, 2007) points at the 2005 riots in Lozells (Birmingham) involving African Caribbeans and Asians against each other as a consequence of the polarisation inherent in ethnic categorisation.

In empirical terms, a careful analysis of insights generated by social psychological research on categorisation is capable of suggesting some evidence to support this position. Divisions between 'us' and 'them', 'insiders' and 'outsiders', which in turn presuppose a cognitive binarism of diametrically opposed categories, have indeed been observed by social identity theorists (Tajfel & Turner, 1986) and self-categorisation theorists (Oakes, Haslam, & Turner 1994; Turner, Hogg, Oakes, Reicher & Wetherell, 1987). Sears, Fu, Henry, & Bu (2003), import social structural theories of group

competition, such as realistic group conflict theory (Bobo, 1983), sense of group position theory (Blumer, 1958) and social dominance theory (Sidanius & Petrocik, 2001), to understand groups' tendency to construct those outside of the group as the 'oppositional other' in all sorts of resource situations. In an Austrian context, empirical evidence of exclusionist responses among parts of the ethnic majority emerge from nationalist rhetoric, in which a 'black-and-white' worldview constructs 'good' in-groups and 'bad' out-groups, separating 'us' from 'them' (see Wodak, 1990, 1991, 1994, 1996a, 1996b, 1997a, 1997b, 2000). This is further illuminated in Reisigl and Wodak's detailed linguistic analysis of a variety of relevant political statements, texts and documents that assume 'polarizations, black-and-white portrayals and Manichean divisions into good and bad', give rise to 'a sharp "us" and "them" pattern' and 'construct a world of "insiders" and "outsiders"' (2001, p.56, 96, 105, see also Wodak & Matouschek, 1993; Wodak & Reisigl, 1999, 2000). Assessments, comparisons and social competition between groups, which are used to define the self (Tajfel, 1978, 1981), are suggested to be linked to the frustrations of not being granted access to the dominant group (Liebkind, 1992; Tajfel & Turner, 1986). However, this assumes that comparisons are always made against the backdrop of a common identity and that the relationship with the majority group is all that matters. The following section attempts to derive insights into whether minority ethnic communities organise themselves in terms of a common community, which subsequently can be represented for a variety of purposes.

6 Further Problems of Ethnic Categorisation/Community

DRE identifies ethnic communities as ‘people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants’ (DoH, 2005, p.11). This definition assumes large parts of the theoretical investigations underlying this review: firstly, that it is possible, and indeed worthwhile, to identify ethnic communities in an attempt to address discrimination and disadvantage; and secondly, that such an approach can achieve equality based upon community engagement.

The former point is about the widely generated definitions of ethnic communities that imply and presuppose a ‘unity of experience’; in doing so, the variability and contestability of experience is neglected. The fundamental belief in the unity of experience to an ethnic community is corroborated by one of the best known theoretical writers on ethnicity Anthony Smith, who claims that an ethnic community is ‘a population whose members believe that in some sense they share a common descent and a common cultural heritage or tradition, and who are so regarded by others’ (Smith, 1986, p.192). Despite the fact that many minority groups present themselves in homogenous and consensual ways, mainly during early migration and settlement to negotiate cultural rights (Ali, 1991), we should not ignore the appearances from ‘leaders’ of minority communities (such as representatives of the Muslim Council of Britain or the chairman of local Mosque committees), who may not be capturing the views and needs of all community members (Dahya, 1974; Werbner & Anwar, 1991). For instance, the growing participation of Muslim youth in political organisations and the increase in social tensions

and unrest has prompted questions about the effectiveness of elder male-dominated ethnic representation in community engagement initiatives (Michael, 2004)⁹. Male elders are *metonymically* projected from ethnic minority communities and subsequently those communities are treated as homogenous. Lakoff (1987a; 1987b), based on elaborations of Rosch's prototype theory¹⁰, defines *metonymic models* as follows:

Metonymy is one of the basic characteristics of cognition. It is extremely common for people to take one well-understood or easy-to-perceive aspect of something and use it to stand for the thing as a whole (...). (1987a, p.77).

The process of taking 'a [particular] member of or subcategory as metonymically [standing] for the whole category for the purposes of making inferences or judgement' (Lakoff, 1987b, p.71) is indeed a highly salient characteristic of DRE. While DRE does make reference to children, older people and refugees and asylum seekers as particularly vulnerable categories within minority ethnic groups, it neglects women. The consequences and limitations of this may be that it positions minority ethnic men as 'standing' for or the 'expert' on minority communities, which could act as a bottleneck for both representation and resources, and thus produce racist effects even when no explicit racist intentionalities can be identified. Internal power relations within groups may disadvantage women so that their views are unaccounted for (Anthias & Yuval-

⁹ A recent poll conducted for Channel 4's *Dispatches* programme provides empirical evidence that less than four percent of British Muslims think that the Muslim Council of Britain, which in recent years has dominated the representation of British Muslims, represents them (see Malik, 2006).

¹⁰ Eleanor Rosch (1978) first challenged the classical notion of all-or-nothing categories by proposing the probabilistic view of categories. Also known as prototype theory, it argues that membership in certain categories is not determined by necessary and sufficient criteria, but by varying degrees of similarity to a prototype.

Davis, 1992; Bhabha, 1999; Deveau, 2000; Okin, 1998, 1999a, 2002; Phillips, 2005; Sahgal & Yuval-Davis, 1992; Schachar, 2001; Southall Black Sisters, 1990; Spinner-Halev, 2001; Yuval-Davies, 1999; Yuval-Davis, Anthias, & Kofman 2005; *Women Against Fundamentalism*, 1990).

Feminist psychologists could offer a possible way out of this problem. The various insights and critiques derived from an analysis of the neglect of women in the history and shaping of psychology is a potentially fruitful way of attempting to approach and take account of the neglected voices of minority women in community discourses. The self-conscious effort to reflect on questions of context, power and agency, intended by feminist psychologists (see for example, Benjafield, 1996; Furumoto, 1980, 1988, 1989; Furumoto & Scarborough, 1986; Goodwin, 1999), could develop a model of subjectivity and culture that would take account of the considerable differences between minority ethnic men and minority ethnic women, as well as between minority women and non-minority women. Such an approach could potentially enable clinical psychology to take a model of multiple intercultural and intracultural discourses in an effort to come to grips with diversity.

7 Essentialism and Category Relations

Despite all obvious differences within minority groups, we should not ignore the existence of some partial and significant shared experiences between them (Jenkins, 1996). It could be that cultural practices have different meanings for 'insiders' and 'outsiders' (Anthias, 2002), in that we possibly grasp and understand the experiences of

minority ethnic women through the Western sense of self-determination, which may be incompatible with the alternative concepts used by minority women (Mountis, 1996). The solidarity that ethnic communities frequently display possibly provides protection from social and political exclusion, and access to resources when members act under the aegis of those 'communities' (Alleyne, 2002; Gilroy, 1982; Jenkins, 1994; Kukathas, 2003; Michael, 2004; Nazroo, 2006; Nazroo & Karlsen, 2003; Solomos, 1998; Spelman, 1990). For instance, studies have shown that ethnic identity is an important political tool for Aboriginals in Australia and Maoris in New Zealand (Morin & Saladin d'Anglure, 1997). Another example is presented by Verkuyten, van de Calseijde & de Leur (1999), who show how Moluccans in the Netherlands define the essence of the category Moluccans in ethnic/cultural terms, to justify social boundaries and claim special recognition and rights for their unique identity. In just this way during the 1970s and 1980s in the UK, some migrants from the Caribbean and South Asia took on a political identity of 'Black'. However, as the Parekh Report on the Future of Multiethnic Britain (2000) discussed, the 'Black' identity is not one upon which communities are built (see also Ang-Lygate, 1997; Hazareesingh, 1986; Modood, 1988, 1990; Modood et al. 1997; Sudbury, 2001).

To speak of 'the black community',..., and so forth, is to refer accurately to a strong sense of group solidarity. But it may also imply a homogeneous set, with fixed internal ties and strongly defined boundaries, and this is a hopelessly misleading picture of a complex, shifting multicultural society (Parekh, 2000, p.27).

Similarly, we can argue that the label ‘ethnic community’ whether imposed by powerful ‘outsiders’ or articulated ‘from within’, inevitably essentialises and simplifies a far more complex and internally divided ‘social location’ (Alibhai-Brown, 2000; Anthias, 2002; Feuchtwang, 1990; Kukathas, 2003)¹¹. Gelman *et al.* (1994, p.344) define psychological essentialism as the widespread assumption that there is an ‘underlying nature, or category essence (...) thought to be the casual mechanism that results in those properties that we can see’ (see also Allport, 1954; McGarty *et al.*, 1995; Medin, 1989; Medin & Ortony, 1989; Rothbart & Taylor, 1992; Sherif, 1948; Yzerbyt, Rocher, & Schadron, 2001). By essentialising minority and majority communities, and dividing the social world into two sets of neatly circumscribed and mutually exclusive categories, empirical complexities are also simplified (Verkuyten, 1997, 2003). As such, there is a very extensive social psychological literature on the use of stereotypes of ‘self’ and ‘other’ in the construction of ethnic categories, along the direction of minority status and power differences in comparison to the majority group (Oakes *et al.* 1994; Turner *et al.* 1987). In contrast, Verkuyten’s (1997) findings concerning the construction of ethnic communities, obtained through discussion groups with Turkish residents in Rotterdam, show that the articulation of ethnic community identity involves a variety of possible category relations, including differences within the group, comparisons to other ethnic minority groups and to the Dutch. Verkuyten’s contribution provides empirical evidence for a de-essentialist model of ethnic community identities as changeable and temporary points of articulation between various referents or category relations (rather than natural, inevitable, and

¹¹ To provide just one relevant example, Masud’s (2003) qualitative study of Pakistanis living in Nottingham highlighted that the unitary view of Pakistanis, as suggested by Anwar, (1979), in the development of local services for Pakistanis, overlooked internal diversities, in particular religious backgrounds, which resulted in Pakistani Christians feeling that their needs had not been accommodated in community services.

unchangeable, and therefore essential), similar to the type observed by social scientists (Anthias, 1992; Carrithers, 1992; Fredman, 2001; Hall, 1992; Horowitz, 1985; Kymlicka, 1995; Modood, 1998; Tully, 1995). We may still wonder if social psychological studies of essentialism/de-essentialism yield similar insights. Haslam, Rothschild & Ernst (2000), to name one relevant research, present the following argument: much evidence concerning whether people hold essentialist beliefs about minority communities is based on theoretical argument (Rothbert & Taylor, 1992); with limited empirical attention to ethnic categories (Hirschfeld, 1996); and although it seems to be an article of faith among social theorists that minority groups are essentialised within the dominant culture, psychological evidence for this claim is scant. Haslam et al's (2000) empirical assessment of these claims suggests that the existence of essentialism in social beliefs is not monolithically associated with devaluation and prejudice. Verkuyten's (2003) more recent study of how Dutch and ethnic minority people use essentialist notions of social groups adds support to Haslam et al's (2000) finding, insofar as the definitions and use of essentialist notions by both Dutch and ethnic minority participants were not necessarily oppressive and de-essentialism was not necessarily progressive. Even more relevant to this reviews interest is Barker and Galasiński's (2001) exploration of ethnic categories on the Poland-Ukrainian border. They demonstrate how the definition and negotiation of what it means to be Polish, by elderly Poles, was constructed through comparisons with others and changed over time and place. For example, the changes that were engendered by the Second World War and the subsequent hostilities between the polish and Ukrainian communities influenced or modified the set of dispositions associated with what it is to be Polish. Barker and Galasiński (2001) hold ethnicity to be a culturally

specific naming, constituted in and through discourse, rather than being a universal entity or set of traits possessed by ethnic groups.

It is, however, worth pointing out that several scholars have presented experimental evidence suggesting that people's reasoning about 'natural kinds' (Atran, 1994; Keil, 1987; 1989) or certain social categories including those defined by ethnicity (Hirschfeld, 1994) tend to be based on essentialist thinking (Haslam et al. 2000; 2002). For example, Gelman, Coley, & Gottfried's (1994) position is that the idea of different human races comes from essentialist beliefs, which are part of the intuitive biology module (see also Atran, 1990, 1994; Boyer, 1994; Hirschfeld, 1994). As Atran (1990, 1994) argued, intuitive biology predisposes humans to set up taxonomies of *living kinds* for animals. Gelman et al. (1994) have done empirical developmental work with children, producing evidence that children spontaneously attribute 'essences' to living kinds. Their findings show that children consequently also take it for granted that living kinds have their own invisible internal workings, that these internal workings cause certain behaviours, that attributed essential characteristics inevitably develop or grow, and that the attributed identity is permanent, despite changes, because something 'inside' is regarded as fixed. However, there are equally compelling psychological reasons for why the reduction of human cognition to category relations is untenable. Seminal psychological categorisation studies (for example Brubaker, Loveman, & Stamatov, 2004) have revealed that categories do not exist in a cognitive vacuum, but are conceptualised through, and are therefore firmly embedded in, more complex sets of ideas or theories about the world. Brubaker et al. (2004) stress that ethnicity involves more than the classification of social

actors by providing ways of ‘seeing the social world and interpreting social experience’. To account for such broader theories of the world they draw on the psychological notions of schemas, defined as ‘complex knowledge structures’ that are simultaneously representations and ‘processors’ of information: schemas ‘guide perception and recall, interpret experience, generate inferences and expectations, and organise action’ (Brubaker et al. 2004, p41 & 43). Moreover, while most schemas are applied ‘automatically, beyond conscious awareness’ by many people much of the time, they are ‘not forever barred from awareness...it is entirely possible to foreground and describe [them]’ (Strauss and Quinn, 1997, p46). In other words, although some schemas are widely shared and tend to inform a non-reflexive processing of information and interpretation of the world, people are capable of bringing them to the forefront of the consciousness, of critically interrogating and revising them. Agency and historical change are thus compatible with a view of ethnicity as a ‘schema-guided’ way of seeing the world.

Furthermore, Ulric Neisser has summarised much psychological work on concept formation and categorisation that underlies the significance of theories, or ‘cognitive models’, in determining which objects or phenomena are grouped together as belonging to the same category. Neisser thus argues that ‘categories are relational to systems of thought’ and that ‘a category is always defined by reference to a cognitive model’ (1987, 12; 22). Medin and Wattenmaker (1987) have similarly argued against the view that categories are based on perceptual similarities alone. Instead, they argue, ‘concepts are embedded in [naïve] theories’ and ‘theories play a significant role in determining which

properties are [deemed] relevant' (1987, pp.28, 35). In other words, perceptual features do not explain, but would appear to underdetermine, why people form particular categories. The importance of theories reintroduces the social to our discussion and underlines the fruitfulness of approaching the issue of categorisation from an interdisciplinary perspective that complements psychological insights and sociological data and theorising. It certainly would exceed the scope of this review to engage with on-going psychological debates surrounding the issue of essentialist thinking, such as the question of whether social categories are conceptualised by a separate domain (Hirschfeld, 1994) or if, alternatively, essentialist thinking is 'imported' from the 'natural kinds domain' and merely applied for the purpose of reasoning about social categories (Aron, 1994). Suffice it for our purposes to highlight how essentialist thinking clearly underlies some of the ideas put forward by DRE: not only by the definition of ethnic communities employed, but also by the belief that community members have the same status and positioning.

7.1 From Essentialism to institutional discrimination

The Macpherson report on institutional discrimination in the Metropolitan Police Force provides us with a clear argument of what essentialist thinking and/or stereotypes has to do with institutional discrimination (1999)¹². The report postulates that unconscious taken-for-granted assumptions about minority people may be transformed into consciously or 'unwittingly'¹³ articulated racist practices and discourses, thus turning essentialist thinking and stereotypes into institutional racism and discrimination. DRE's

¹² The MacPherson Report is the official report from the inquiry into the death of Stephen Lawrence

¹³ The notion of 'unwitting' is linked to ideas about unconscious and unintentional racism in the MacPherson report.

recognition of discrimination in mental health institutions therefore is extremely significant; however, as the following analysis will make clear, by removing institutional practices from the analysis, it has to be wary of the dangers of maintaining or reproducing unequal structures and power relations.

DRE describes the discrimination of services as a product of '*everyone* involved in planning, managing and providing the services' (p.22). This could be interpreted as exonerating the formal structures of the mental health services and of watering down the definition of discrimination within the services to make it acceptable to all. If all are guilty, then none are guilty; if all individuals are discriminatory, then the formal structures of services are not discriminatory as such: it just happens that way. The report of the David Bennett inquiry (2003), on the other hand, views discrimination as stemming from the structural features of institutional racism in mental health care and therefore the locus of effectivity is quite different. If discrimination is viewed as a product of the attitudes and behaviours of service providers, DRE does not need to ask about structures and can focus primarily on the 'cultural capability' of service providers¹⁴ (p.22).

However, a discriminatory practice, as well as being one that has explicit service provider facets, can be a product of inexplicit or unwitting racist procedures, which may lead to processes and frameworks impacting differentially on minority ethnic groups, serving to disadvantage or exclude them. An example may be access to psychological therapy that is based on individuals being on a list for a certain amount of time. If some ethnic groups

¹⁴ This point has been stressed by Wight (2003), in his analysis of the notion of institutional racism in the MacPherson report.

lack information on the criteria for access to psychological therapy or if they are less likely to gain the GP referral required, this may produce racist effects.

Nonetheless, given that the attitudes and practices of professionals in mental health services has a large impact on the success of developing a discourse with minority communities and culturally appropriate services, the DRE focus on cultural capability seems justified. However, underlying such frameworks is an all too narrow, and not particularly helpful, conception of culture, which also ignores the omnipresence of power relations. In the following discussion, the contribution and relevance of clinical psychological work on and models of cultural competence are stressed.

8 The Essentialism of Cultural Competence Models in Clinical Psychology

The defining characteristics of models of cultural competence in clinical psychology include: gaining some sort of insight into the client's cultural perspective (along with a corresponding acknowledgement of difference and impact of racism) (Atkinson & Lowe, 1995; Barrett & George, 2005; Daniel, Roysircar, Abeles & Boyd, 2004; Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002; Gonzalez, Biever, & Gardner, 1994; Harris & Skyles, 2005; Helms & Cook, 1999; Judd & Beggs, 2005; Pinderhuges, 1995; Summers & Jones, 2004); a focus on power (Atkinson & Lowe, 1995; Richardson & Molinaro, 1996; Roysircar, 2003) and communication (Sodowsky, Taffe, Gutkin & Wise, 1994; Sue, Arredondo & McDavis, 1992); traditional systems and healers (Leong, Wagner & Tata, 1995); and practical concerns of timing and context for discussions of

difference (Gopaul-McNeil & Brice-Baker, 1998; Maxie, Arnold, & Stephenson, 2006; Wilkinson & Spurlock, 1986).

The above cited qualities would suggest that cultural competence models offer the possibility of gaining some sort of insight into the experiences of minorities, and importantly, institutional structures and contexts (see Gullestad, 2004; Hwang, 2005; Sivanandan, 2006). However, Korchin (1980) seems to put brakes on any type of critical analysis of dominant practices:

In order for clinical psychology to develop a cross-cultural approach that views the behaviours of minority individuals in terms of their meanings within particular subcultures...clinical practices obviously need refinement and reconceptualisation if they are to serve minority needs better, but it is too extreme to argue that existing concepts, institutions, and practices must be discarded or that a solution can be reached only through radical social change. Perhaps of greatest importance, however, is the need to increase our commitment to educating larger numbers of qualified minority psychologists more concerned with studying and serving their own ethnic groups, in the process enriching the education of white students (Korchin, 1980, p.262).

Increasing the number of ethnic minority psychologists (partly based on the notion that these psychologists will be more ethnically sensitive, at least to clients from their own group) has been emphasised in the literature (Iwamasa, 1996; Martinez, 1994; Porter,

1994; Rogler, Malgady, Constantino, & Blumenthal, 1987; Sue, 1977; Sue & Zane, 1987). An implication of this is that clinical practice with minorities is not seen to be equally important for all clinicians or for all areas of clinical practice, with the possible devaluing of work in this area, which in turn could have racist effects (see Gould, 1996; Richards, 1997). Using minorities to work with minorities runs counter to research in intergroup relations, which suggests intergroup contact is important in reducing the majorities' discrimination against minorities¹⁵, insofar as it puts a stop on non-minority clinicians working with minority clients. The assumption that minority clinicians can provide minority clients with a culturally and psychologically sound framework for understanding their distress, on the basis of a common ethnicity, over clinicians from a different ethnic background, highlights the propensity for essentialist thinking. This is clearly reflected in Barrett's (2005) model of cultural competence:

The clinician must consider whether or not he or she is the best person to conduct the evaluation, given the range of differences in background between him-or herself and the client. If there is a lack of availability of professionals that are more qualified by virtue of their professional training and their cultural, racial, or ethnic similarities to the client, the clinician should seek appropriate education and consultation to facilitate work from a multicultural perspective (Barrett, 2005, p.109).

¹⁵ The British social psychologist Miles Hewstone in a meta-analysis of 500 studies of intergroup contact, found that more contact is associated with less prejudice. Hewstone's findings played a key role in the report from the Government's Commission on Integration and Cohesion, which aims to encourage more opportunities for contact between groups (Bunting, 2007).

Essentialist thinking arises in a wide range of responses to the notion that those who share a common ethnicity also share common views, responses such as ‘minority ethnic community members can better represent minority interests’ (Summers & Jones, 2004 p.693), ‘status contradiction’ arising between a minority psychologist and a white client (Halsey & Patel, 2003 p.30), and as causes of the underutilisation of mental health services by minorities (Coleman, Wampold, & Casali, 1995; Flaskerud, 1990; Sue, 1998; Vessey & Howard, 1993). A brief overview of some key literature in the area is ambiguous: in some studies a preference for therapists who are similar was found (Abreu & Gabarain, 2000; Coleman et al. 1995), and produced better outcomes (Karlson, 2005; Maramba & Nagayama Hall, 2002), while other studies found little or no difference in preference (Speight & Vera, 1997; Vera, Speight, Mildner, & Carlson, 1999), with no significant impact on outcomes (Shin et al. 2005). Importantly, however, research in this area has helped to establish the legitimacy of researching *process* issues rather than broad issues of identity categories (Burman, Gowrisunkur, & Walker, 2003; Comas-Diaz & Jacobson, 1995; Karlson, 2005; Sue, Fujino, Hu, Takeuchi & Zane, 1991; Shin et al. 2005), such as the impact on communication (Jenkins, 1990; Mehlman, 1994; Ridley, 1984), transference and countertransference (Comas-Diaz & Jacobson, 1995), and the overpathologising of clients who are culturally different (Whaley, 1997). Such analyses invariably invoke both structure and context: in the relationship between client and therapist; between therapy and institutions; and between knowledge and power. The recognition of structure and context is crucial because as revealed by Yzerbyt et al’s (1997) empirical findings, essentialist beliefs serve to rationalise existing social arrangements, by providing explanations (such as a shared ethnicity reflects shared

experiences) for the differential treatment of groups (thus a psychologist who shares the same ethnicity as their client can offer a better treatment, than a psychologist with a different ethnicity). The crux of this thesis is that systems and structures that might be reinforced by essentialist thinking should also be examined.

8.1 Structures and cultural models

Invoking the critique of Foucault (1980), Halsey and Patel (2003) emphasise that clinical psychological practice is both structuring and structured, simultaneously constitutive of and shaped by the institutional context in which it is located. Miller (2002), and Riggs and Choi's (2006) respective reflections on clinical psychology's approach to discrimination and ethnicity suggest that it is unsatisfactory insofar as the existence and role of institutional power appears to be absent. Similarly, Karl Marx (1818-1883) argued that psychology allows far too little by way of understanding the sociocultural and political-economic embeddedness of the human mind, and therefore narrows and simplifies its own findings (see, Teo, 2001).

It may also be argued that psychology's parallel use of a variety of psychiatric ideas and concepts concerning mental health constitute an example of its embeddedness or reproduction of existing power structures (Teo, 2005). The cultural and clinical authority of Western mental health concepts can be discerned in various cross-cultural studies of mental health in which non-Western models are examined in their 'difference' to and from Western models¹⁶. Hermans and Kempen (1998) have argued that dominant

¹⁶ For example cultural differences in: theories of causation (Fabrega, 1989; Lewis-Ferandez & Kleinman, 1994; Murdock, 1980); use of diagnostic categories (Draguns, 1995; Fabrega, 1992, 1993; Jilek, 1982; Rogler, 1993; Weiss,

approaches to knowledge have formed static conceptualisations of culture (see also Josephs, 2002; Shweder, 1990; Squire, 2000), which contributes to the reification of culturally homogenous ethnic groups. Kleinman (1995) argues that Western mental health discourses have been increasingly organised around undermining cross-cultural differences so that mental health, in a range of cultural contexts, can be reasonably thought of in mainly Western terms. This orientation undermines the ways in which the self is understood in different cultures (e.g. Bhatia & Ram, 2001; Mkhize, 2004).

Kremer and Schermbrucker (2006) offer a theoretical explanation that appears to be applicable to Kleinman's observation. They suggest the ease that we experience when there is consistency between our thoughts, feelings and actions, leads us to aspire to minimise cognitive dissonance, and one of the easiest ways to do this is to eliminate, avoid, or negate difference. In this way, it may be argued that Western understandings of mental health threatened by the encroachment of non-Western models of mental health develop their own explanations of mental health in non-Western communities, which preserve Western constructs of mental health. Depression and somatisation, for example, are typically seen as different culturally informed ways of expressing biologically similar disorders (Beliappa, 1991; Gaw, 1993; Hussain, Creed & Tomenson, 1997; Ineichen, 1990; Kawanishi, 1992; Rack, 1982). However, Kleinman (1987) suggests that the reliance on a biological definition of disease crucially undermines an understanding of

Raguram & Channabasavanna, 1995); conceptual models of mental health problems (Pote & Orrell, 2002); stigmatisation (Carter & Neufeld, 1998; Cole, Leavey, King, Johnson-Sabine & Hoar, 1995; Littlewood, 1998; Murphy, 1976; Raguram, Weiss, Channabasavanna & Devins, 1996); and whether over-representation in psychiatric morbidity indices of, in particular, migrating ethnic minorities can be explained through preferences for alternative cultural-based treatments (Helman, 1990; Klienman, 1980; Littlewood, 1992; McKenzie, 1999; Sharpley, Hutchinson, McKenzie & Murray, 2001).

how different the culturally shaped illness may be, including symptoms, help-seeking behaviour and course of illness. Some recent studies of Asian women's accounts of depression have noted descriptions and experiences similar to the standard Western symptoms of depression, but also standard symptoms that were not present (those relating to a loss of meaning in life and self-worth) (Fenton & Sadiq-Sangster, 1996), and alternative non-self descriptions related to the communal embedding of themselves (Burr & Chapman, 2004; Chew-Graham, Bashi, Chantler, Burman & Batsleer, 2002). It follows that at least the form that the disease took was different. This would suggest that in spite of similarities across minority ethnic and Western understandings of mental health, there are important differences, which in turn would suggest that a Western approach to mental health in minority groups might not be helpful for the experiences of some ethnic groups (Schumaker, 1996).

It is precisely this conceptual difference that appears to underlie the concern for culturally sensitive models. However, criticism has been raised about the possibility for a single model of cultural competence that can be applied to an entire range of cultural concepts, contexts and differences (Martinez, 1994; Maxie et al. 2006; Rice & Donohue, 2002; Sue, 1998). It may be objected that such criticisms are based on essentialist thinking, that presuppose the existence of inherent differences between various cultures (Teo, 2005). For instance, Paranjpe (1998) provided a historical comparison of Western and Indian psychology, and showed surprisingly many commonalities as well as significant differences between the two traditions. In response to such possible counter-criticisms, it should be highlighted that the cultural eclecticism of the models, such as African

psychology (Holdstock, 2000), Anti-racist psychology (Howitt & Owusu-Bempah, 1994), and Harré's reading of Indian, Chinese, Japanese, and Islamic thought systems (2000), make clear that no one model can explain human cognition or experience in all its complexity (see Fay, 1996). Consequently, it is through a more context-sensitive and flexible application of different paradigms and models that clinical psychologists can make sense of people's experiences, a proposition that continues in the following and final analytical section of this review.

9 Post-Cultural Competence

Much ground has been covered in this review: before we can proceed with the view that a context-sensitive and flexible interpretation of experience is a promising model/approach for clinical practice with various cultural groups, it is necessary to recapitulate how and why we have arrived at this approach.

The starting point is that despite the challenges aimed at 'ethnic' communities not representing a collective and unified identity (Anthias, 1992; Hall, 1992; Modood, 1998), ethnicity continues to be a pervasive feature of discrimination in mental health services. For instance, the rate of admission to mental health services is higher than average for women belonging to specific ethnic groups, including White Irish and Black (Count Me In, 2005).

Ethnicity can function as a powerful argument because multicultural notions insist that all ethnic groups have a right to their own culture (Cooper, 2004; Deveaux, 2000; Gutmann,

1992; Kymlicka, 1995; Parekh, 2000; Schachar, 2001; Young, 1990)¹⁷. However, social psychological studies on essentialism have shown that the idea of fundamental and inherent cultural differences is also used to maintain the *status quo* and homogenise the minority group (see Yzerbyt et al. 1997). The somewhat narrowing application of a specific set of cultural concepts or conversely the application of a broad set of cultural concepts, in cultural competence models, is similarly in danger of perpetuating essentialist thinking (Teo, 2005). It is only now that we can proceed with a discussion of how the essentialism of minority groups can be avoided, while DRE's ambition to engage minority communities and produce a useful tool or cultural model for practice, remain intact.

9.1. Cultural competence reframed: human dignity and human rights

In response to the problems of essentialism we could advocate for equality to be based upon every individual being treated as a citizen, not as a member of particular ethnic group. It may be objected that such an approach is based on a Western liberal theory of individuality and autonomy, which may be in direct conflict with the concept of collectivism in some minority groups (Elias, 1978; 1982). In the Eastern cultural context people's sense of self is thought to be bound up in collective aims and in the Western cultural context people's sense of self is thought to be bound up in individual aims.

Ghuman (2005) and Bhardwaj (2001) have suggested that the clash between family values of interdependence and the public values of personal autonomy constitute

¹⁷ For instance, UNESCO and the UN recognise the rights of 'peoples to self-determination' or to pursue their culture, because many ethnic minorities find it difficult to preserve their cultures in the midst of an alien culture.

important factors in the increased risk of suicide and self-harm amongst young minority women. Here, there is the potential to argue that clinical psychology may not be very helpful to these young women because clinical psychology is not wholly neutral and it does have a conception of what kind of life is worth living. Particularly, the upholding of the autonomy of the individual is held paramount¹⁸ (see Afuape, 2004; Allwood, 2005; Barrett & George, 2005; Cushner & Brislin, 1996; Lunt, 2005; Markus & Kitayama, 1991; Oyserman, Coon & Kemmelmeier, 2002; Shams & Jackson, 2005; Summers & Jones, 2004).

We may wonder if there are any concepts for clinical practice that are not emic constructions specific to certain cultural models. Fredman's (2001), scepticism about the notion of autonomy and her alternative proposition of human dignity as underpinning equality, provides a promising universal concept to transfer to clinical practice. Dignity it is thought does not have the pitfalls of personal autonomy as it is found not just in the dominant culture but is a value inherent in the humanity of all people (Fredman, 1999; Dworkin, 2000).

The principle of individual dignity notably constitutes part of the mission statement in section 3 of the Equality Act 2006, which aims to encourage the development of a society in which:

¹⁸ It should be noted that there is another side to the coin: it may also be argued that the minority groups collective values and traditions are in conflict with the individual values and beliefs of minority women. This review, however, is concerned with the connection between the minority group values and the majority group values.

People's ability to achieve their potential is not limited by prejudice and discrimination, there is respect for and protection of each individual's human rights, there is respect for the dignity and worth of each individual, each individual has an equal opportunity to participate in society, and there is mutual respect between groups based on understanding and valuing of diversity and on shared respect for equality and human rights (Part 1, Section 3, p.2).

A prerequisite to respecting individual dignity is recognising each individual's human rights. Human rights, however, are also often held to be a Western concept. This is due to the fact that only a limited number of African and Asian countries were represented in the initial construction and adoption of The Universal Declaration of Human Rights (Banton, 2001). However, research studies of international interpretations of the Universal Declaration of Human Rights show a consensus in concepts of human rights (Clémence, Devos, & Doise, 2001; Doise, Spini & Clémence, 1999). Furthermore, some indigenous groups have found that incorporating human rights discourse into that of their traditional culture can contribute to the advancement of their political and their cultural goals (Niezen, 2003).

The justification for models of clinical practice to be based upon a human rights approach is that the good that human rights seek to achieve is the good for human beings, and most human beings benefit most of the time if their human rights are respected. However, if our argument that autonomy is a culturally specific concept is meaningful, then we must presume that the concepts of human rights as well as dignity will also be culturally

determined¹⁹. This does not mean that no universal concepts exist. Psychologists could be active in the task of demonstrating that certain concepts have global significance but not to assume that they have universal validity²⁰. Recognising the socio-historical and political-economic embeddedness of cognition and experience can allow us to be context-sensitive, while the parallel use of human rights, to identify consensual and mutual aspects of human values can allow us to be more universal than esoteric or abstract²¹.

As Afuape (2004) makes clear, a human rights framework is particularly crucial for clinical psychologists working with refugees and/or asylum seekers, because the experiences of refugees and/or asylum seekers are firmly embedded in socio-historical and political-economic circumstances and relations of power (Afuape, 2004; Alba & Nee, 1999; Bauman, 1999; Boyd-Franklin, 2003; Boyd-Franklin & Hafer Bry, 2000; Chantler, 2005; Holland, 1992; Mahtani, 2003; McDaniel, Lusterman & Philpot, 2001; Mearns & Thorne, 2000; Orford, 1992; Patel, 2003; Proctor, 2004; Thomas, 2004; Weine et al. 2006).

¹⁹ It is noteworthy that the Commission for Equality and Human Rights chair Trevor Phillips wants to replace 'human rights' by 'mutual respect' or other phraseology (see Walker, 2007).

²⁰ For example, research into global/universal ethical principles for clinical practice appears to be among the most widely research topics in contemporary clinical psychology. The ever-expanding literature in this area has identified principles related to human rights and human dignity as foundational values in international codes of ethics (Callahan, 1982; Fisher, 2003a, 2003b, 2004; Frankel, 1994, 1996; Gauthier, 2004; Leach & Harbin, 1997; Lindsay, 1996; Pack-Brown & Williams, 2003; Pettifor, 1996, 2004; The Ad Hoc Joint Committee for the Development of a Universal Declaration of Ethical Principles for Psychologists, involving The International Union of Psychologists, The International Association of Applied Psychology, and The International Association for Cross-Cultural Psychology (2004); The Centre for Global Ethics (1993); The European Federation of Psychologists Associations (1995); The TRI-Lateral Forum, consisting of the Canadian Psychological Association; the American Psychological Association, and the Mexican Psychological Society (2000).

²¹ For instance, the British Psychological Society recent declaration against torture recognises that certain practices are universally bad for all people (BPS, 2005).

Opinions on the usage of a human rights framework to working with minority ethnic groups are likely to vary amongst clinical psychologists. Some questions that may arise in any such debate include: do clinical psychologists operate with discourses based on hierarchical individual/collective, self/other relations that are in need of deconstruction? Is the study of race and ethnicity in clinical psychology similarly complicit in the ongoing reproduction of inequalities based on normative judgements of the nature of ethnic groups? Can clinical psychological research on minority ethnic groups ever be innocently descriptive or are they perhaps inevitably prescriptive and hence profoundly political? Does the notion of cultural competence do anything other than define and fix a normative subject position for minorities? Who is excluded from this group which our models of cultural competence end up delineating and/or reproducing? Whose voice is silenced, whose views are marginalised? And importantly, what are the clinical implications of policy accounts of race and equality? It is hoped that that these questions will provide stimulus for future research in an exciting and important field.

10 Conclusion

This review has attempted to reflect and capture some of the dynamics involved in mental health services 'handling' of equality and diversity. It has made four interrelated theoretical and empirical arguments. Firstly, it was shown that DRE's central objective of engaging with ethnic communities, as one of the means of seeking inclusiveness, was not able to account for intra-group distinctions. Consequently, the minority group is essentialised and seen as homogeneous. A picture of heterogeneity *within* minority groups emerged through the revelation of various intergroup and intragroup category

relations and comparisons, as articulated by social psychological studies. Secondly, it was argued that structure/context and essentialism are co-dependent, and that institutional context must be accounted for. Thirdly, the diffusion of essentialism in clinical psychological models and approaches to cultural competence models was revealed. While degrees of sameness between Western and minority ethnic concepts of mental health clearly exist, it was argued that any attempt to try to abstract a set of generalised characteristics that can be valorised within a model of cultural competence, could result in the privileging of a particular (Western) version of mental health. Fourthly, an outline of a human dignity and human rights framework capable of holding the context-specific aspects of experience as well as the flexible interpretation of various universal values was presented.

The resulting picture has been one of warning against the dangers of essentialism and categorisation. This review has presented a suitable analytical framework, which suggests that minority groups do not fit all too neatly into the categories frequently ascribed to them. That much equality thinking and policy has been based on 'ethnic groups' suggests that such categorising may stick. Clinical psychological understandings, however, should attempt to go beyond such labels and, in doing so, acknowledge the complex heterogeneity of human experience.

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‘Can There Be Cultural Competence Without Culture?’

Psychologists’ Discourse on

Working with Minorities

Objectives

The present research examines the discursive ways in which individual psychologists formulate and negotiate their work with minority ethnic clients and through this a consideration of their constructions of cultural competence.

Design

It discusses two qualitative studies that were conducted among clinical psychologists. The first study uses interviews structured by the researcher herself and the second study uses a discussion that was held by some psychologists independent of this research.

Methods

Drawing on discourse analysis this research examines the interpretative repertoires that psychologists use in their accounts of working with minority ethnic clients, the discursive strategies deployed to achieve these accounts, and how these construct a particular version of cultural competence.

Results

In the interviews, cultural competence was found to be constructed in relation to the repertoires of ‘social context’ and ‘individual context’. An interpretative framework in terms of ‘social context’ involved a consideration of the client’s cultural background, and the ‘individual context’ was considered to be a way of formulating the client’s own interpretation and understanding of cultural background. In the group discussion, the key interpretative framework was the ‘individual/curious’ repertoire, which also focused on understanding cultural background in terms of the client’s interpretation.

Conclusion

It is shown that: the psychologists construct various versions of cultural competence in using these repertoires; that there is an oscillation between a risk of reifying minority ethnic groups and a risk of neglecting issues such as ethnic discrimination; and that cultural competence is unavoidably contentious but not necessarily unhelpful.

Part 1

Introduction

1.1 Origins of the Study

This research stems from an interest in the race equality ideas underpinning many Department of Health policies, which are increasingly encouraging mental health professionals to practice in particular ways, in order to maximise the inclusion of minority ethnic groups in mental health services, therefore practicing as culturally competent and capable professionals (Bhui, 2006). The most recent Department of Health policy 'Delivering Race Equality in Mental Health Care' (DRE) (DoH, 2005) is organising regional 'community partnerships' in order to boost connectedness between mental health professionals and minority communities. One of the reasons for this is to counteract the potential for mental health professionals to misunderstand the beliefs and behaviours found in other cultures (McLean, Campbell & Cornish, 2003). For example, it has been suggested that perceptions of aggressiveness in African-Caribbean clients may result from misinterpretation of normal modes of behaviour common in this community, which often seem overly 'loud' or extrovert to outsiders, resulting in inaccurate diagnosis and feeding into the high rates of schizophrenia diagnosis (Littlewood, 1992).

Many empirical studies on cultural competence tend to seek to derive a set of core principles (respect, fairness, collaboration and so on) for clinical practice with a minority client (Daniel, Roysircar, Abeles, & Boyd, 2004; Summers & Jones, 2004). Two key issues arise: firstly, the attempt to formulate *the way* in which mental health operates in a particular culture is too esoteric or too general, to be set into a single comprehensive

model (Rice & Donohue, 2002). The complexities and heterogeneity of Britain's minority ethnic communities, with all their social, linguistic, generational, regional, ethnic and religious diversities, clearly reveal the impossibility that they can be reduced to any one model. Secondly, the way(s) in which principles adopted to work with minorities can be conceptualised as significantly different from principles contained in our code for general practice need to be made clear. Is the actual issue that our general practice guidelines no longer meet the needs of an increasingly culturally diverse mainstream society, rather than the view that our general principles are limited in application to a particular sub-section of the population?

The latter refers to the unmoving position that clinical psychology is limited in its cross-cultural appeal, because it is inherently Western. A highly significant attempt to try to get out of this position has been made by various international psychological bodies that have joined up and put forward shared cultural conceptualisations of principles for practice (e.g. The AdHoc Joint Committee for the Declaration of Universal Ethics for Psychology (2004). In this work, the principles of human rights and dignity are used to exemplify value continuities between various cultures. Central to them is a respect and right for all, especially previously marginalised groups. If values across cultures can be found, we may wonder whether having a general set of professional principles on one hand, and a set of principles largely adapted to minority groups on the other, connote a degree of undue reification or difference, which may be antithetical to rather than a provision of equality. At the same time, however, simply saying that if clinical psychology embraces principles such as human rights it largely will be adaptable to

minority groups is unlikely to settle any controversy or tell us, for example, what is institutional racism and how it should be handled. Equally, however, the idea that there has to be a 'model' of cultural competence is not in the spirit of cultural sensitivity being integral and woven in theory and practice, as a core value, not reduced to a list (Patel et al. 2000).

The argument between those who want to rightly emphasise a cultural re-balancing of what some have seen as a one-sided Western clinical psychology (Patel et al. 2000), and those who think that cultural competence itself should be put to death (Chantler, 2005; Sue, 1998), remains underdeveloped. This study therefore seeks to explore the assessment and interpretation of cultural competence, such as why there is apparently a need for a different type of framework to work with a minority population than with the majority population, through a case example of clinical psychology.

1.2 The Study and its Framework

The study is an exploration of psychologists'²² approaches to working with minorities²³, and what this can tell us about their constructions of cultural competence. As I have discussed above, understandings and constructions of cultural competence are not self-evident, but rather involve various arguments and explanations. A discourse analytic approach can tell us what constructions of cultural competence psychologists use in their

²² Because of the awkwardness of repeating the whole phrase 'clinical psychology' and 'clinical psychologists' each of the many times I refer to them in this paper, I often take the liberty of dropping the 'clinical' and simply talking about psychological and psychologists understandings. Readers should remember that I am referring to clinical psychologists.

²³ Again, instead of repeating the whole phrase 'minority ethnic clients', I will often refer to them as minorities and minority groups.

approach to working with minorities. Such work is valuable as it addresses this gap and further develops clinical psychological understandings of cultural competence and contributes to the policy and training work concerned with professional understandings of, and engagement with, minority ethnic mental health.

The specific aim driving this research is to identify the ways in which individual psychologists formulate and negotiate their work with minorities and through this a consideration of their constructions of cultural competence. The key concerns of this research are therefore: how psychologists work out their position in relation to working with minority ethnic clients; the approaches employed to achieve this; and how these can be seen as constructing a particular version of cultural competence. To meet these research objectives two types of data were used: transcripts from interviews with psychologists; and, a transcript from a psychology group discussion. This use of multi-modal data conveys that I did not rely on one site or one particular view of cultural competence in psychology, therefore, it is hoped, that my research is an insightful and distinctive contribution to this area of study.

1.3 The Structure of the Study

This paper begins with Part 2 which sets a detailed description of the epistemological, methodological basis of my research, and the methods used. I will argue that discourse analytical research can generate valuable data concerning psychological approaches to working with minorities, and that this data can subsequently offer insights into the understandings and constructions of cultural competence. I will then illustrate the

specific participants and materials of this research and go on to describe the analytical procedures used. Finally, the ethics and validity/reliability of using a discourse analytic perspective will be discussed. The analysis of interview transcripts based on a study involving six clinical psychologists will be discussed in Part 4, and the transcript of a group discussion based on a second study involving five clinical psychologists will be discussed in Part 5. The overall picture thus emerging will be of an analysis focused on discursive processes and the complexities of the interactions between cultural competence and the approaches used by psychologists to work with minorities, which will be drawn together in Part 6.

Part 2

Epistemology, Methodology, Methods

2.1 Social Constructionism

My conceptual starting point is two-fold. First, in this research, I begin from the position that the goal of constructing a model of cultural competence that psychologists can use to work with minority ethnic groups, as encouraged by policy and other literature, is possibly unattainable in principle and practice as long as we have no systematic understanding of the frameworks used by psychologists to work with minorities. Second, if cultural competence itself is a matter of debate, involving various arguments and concepts, then it seems logical that arguments will be manifested in the language through which clinicians account for their approach to working with minorities. Therefore, we should focus on construction processes, such as interpretative repertoires²⁴, in talk, and the way these define cultural competence. The epistemological basis for my study is thus that cultural competence derives its meaning from how it is defined by clinicians; this is a social constructionist view. The basic tenet of social constructionism is that people experience the world in terms of their views, and that views are interactionally and communicatively produced (e.g. Berger & Luckman, 1966; Gergen, 1999; Mayr, 2004; Shotter, 1993).

It is therefore doubtful if a survey or questionnaire method would have been suited to this research, given the nature of the issues investigated. This research deals with arguments

²⁴ I explain what I mean by this term in section 2.2.

constructed in talk and therefore favours a qualitative approach. In most qualitative approaches variability in participants' accounts is problematic because they tend to seek to construct a generalised version or model of participants' accounts. From a social constructionist view, however, if there is a strong connection between how we construct things and the situations in which those constructions take place, it follows that there is the potential for variability in the statements produced by participants. Discursive variability does not pose any analytical difficulty for discourse analysts; moreover, in some discourse approaches it is the central feature of interest (Marshall, 1994). Since the variability of constructions is the key interests in the present research, a discourse analytic approach is appropriate, and I shall now describe the discourse approach used in the present study.

2.2 Discursive Psychological Discourse Analysis

Discourse analysis literally means the analysis of 'discourse', which is variously defined as talk, language, text and conversation²⁵ (Wetherell, 2001). It treats language as constructive of things. In other words people 'talk things into their reality'. In this way, things are constructed through discourse. The central feature distinguishing discursive psychological discourse analysis is that, in the now familiar phrase, it treats participants' discourse as a topic instead of a resource (Gilbert & Mulkay, 1984). That is, talk is not treated as a resource to reveal people's underlying opinions or feelings, but rather the talk itself, and what it achieves, is the topic of interest²⁶ (Cameron, Frazer, Harvey, Rampton

²⁵ Sawyer (2002) and van Dijk (1997a, 1997b) summarise the history and use of discourse analysis in the social sciences.

²⁶ It is rooted both in Austin's (1962) speech act theory and in the philosophy of Wittgenstein (1953), which emphasise that language is used to achieve things.

& Richardson, 2006; Potter, 1997). Discourse analysts²⁷ abandon the goal of trying to uncover feelings and thoughts beyond the actual talk²⁸, and concern themselves instead with describing the discursive methods which are used by the participants (Potter & Wetherell, 1987). The focus is on how descriptions, accounts and arguments are organised and managed in talk. For example, the discourse analysis of racism looks at how 'descriptions are marshalled in particular contexts to legitimate the blaming of a minority group' (Potter, 1996, p.129).

Potter and Wetherell (1987) speak of the notion of 'interpretative repertoires' as a key concept of discourse and define it as follows:

Interpretative repertoires are recurrently used systems of terms used for characterising and evaluating actions, events and other phenomenon (p.149).

Repertoires may be characterised by a distinctive vocabulary, particularly stylistic features and the occurrence of specific figures of speech (Wooffitt, 2005). To give one example, in Wetherell and Potter's (1992) study of white New Zealander's talk about Maoris, they found that a 'heritage' repertoire was drawn upon to legitimate racist practices. There is an infinite number of repertoires available to us in everyday talk (Edley, 2001), and the aim of the discourse analyst is to provide closely documented descriptions of the recurrent interpretative practices employed by participants. This

²⁷ From here on discourse analysis is used to refer to the discursive psychological approach to discourse analysis.

²⁸ Because talk is considered to be too variable to be seen as versions of consistent underlying cognitive processes (Wood & Kroger, 2000).

involves identifying the discursive strategies or devices (such as blaming, justifying and narrative building) used to 'put the talk together' in ways that appear reasonable, plausible and authentic (Horton-Salway, 2001). Therefore, this approach helps us to appreciate how the various analytical conclusions to be found in this paper have arisen from the participants' use of different kinds of repertoires and devices.

Finally, there is a psychological trend of increasing discourse analytical studies in the area of ethnic and cultural diversity (Augoustinos & Quinn, 2003; Edley, 2001; Edwards, 1991; Edwards & Potter, 1992; Pratto & Lemieux, 2001; Rapley, 2001; Van den Berg, Wetherell & Houtkoop-Steenstra, 2003; Verkuyten, 1997; 2001; 2005), to which this research aims to contribute.

2.3 Methods

The corpus of discourse material used for this study is derived from two studies: the first study involved interviews with clinical psychologists and the second study involved a group discussion amongst clinical psychologists. The fieldwork took place in the Midlands, North and North-West area of the UK, and was conducted over six months (December 2006 to May 2007).

2.3.1 Study 1: Participants and material

Four semi-structured interviews were conducted with clinical psychologists who self-identified as working mainly with minorities and two interviews were conducted with clinical psychologists who self-identified as working mainly with the White British population. In the latter case, I included this sample in order to try and ensure that as wide a range of views as possible was included. My sampling strategy is best described as ‘opportunistic’ (Silverman, 2001), in that I asked psychologists known to me to pass on information about my study to psychologists that fitted my inclusion criteria (i.e. clinical psychologists that self-identified as working with mainly a minority ethnic population or the majority British White population). Whilst three clinical psychologists from different minority ethnic backgrounds showed interest in taking part in my research, only one of them was able to make time for an interview. Overall, the sample represented diversity with regard to place of geographic practice and the length of post-training experience (Table 1, p.146).

The participants were asked to participate in a study on 'psychological approaches to working with minorities' (see Appendix B). The interviews were designed to include descriptive, constructive and evaluative questions (Spradley, 1979) to explore a range of areas including: experiences of working with minorities; formulation methods; and views on clinical psychological work with minorities (see Appendix C). In line with a discourse approach, the interviews were treated as conversations or interactions (Jacobs & Orchs, 1995; Potter & Wetherell, 1987; Willig, 2001).

Before the interview began each participant was asked to sign a consent form and their permission was obtained to audio tape-record the discussion (Appendix D). Assurances were given that the tapes would be anonymised²⁹. On one occasion the tape recorder malfunctioned early on in the interview and so I had to rely on notes written up during and after the interview. These notes were used at the analysis stage to generate themes. They were not included as part of the fine-grained analysis, because the notes were my reconstruction of the general sense of what my informant had reported, which would allow to a far greater extent my personal perspective to influence the notes (Seale, 1999). The interviews were all transcribed in full. The transcript of my interviews stresses readability (Diamond, 1996); a detailed level of transcription was not necessary given that the analytic focus was directed at the content of repertoires and discursive strategies employed (Verkuyten, 2005)³⁰.

²⁹ Tapes were identified by a pseudonym and the list linking these to the participants real names were kept locked in a separate cabinet.

³⁰ I accept that the transcription is a construction of the interview (Bavelas, 1990; Lapadat, 2000; Riessman, 1993), because as I transcribed, I relied on my own evaluations of the speech in deciding how to write it (Roberts, 1997).

2.3.2 Study 2: Participants and material

The second study consisted of the audio tape-recording of a group discussion on diversity amongst clinical psychologists, which took place independent of my research. I did not take part in the discussion itself or in structuring the group and topic. I used this type of ‘naturalistic’ method³¹ (Potter, 2002), because if constructions are negotiated in talk then a group discussion is a particularly rich source of data (Lynch, 2002; Phillips & Hardy, 2002; Ten Have, 2002; Verkuyten, 1997a; 1997b). The opportunity for the group discussion became apparent during one of my clinical placements in an adult mental health setting. The clinical psychology team had previously planned to conduct a discussion on diversity, and after going through the aims of my study (Appendix E) the team agreed to participate in my research. In total, there were four qualified clinical psychologists in the group and one trainee clinical psychologist. One of the group members also took part in the interviews. This was the only group member that took part in both the group discussion and interview. The use of discourse from the same participant in different contexts is not considered to be problematic in discourse studies, because the focus is on repertoire building rather than typicality (Potter & Wetherell, 1987). Moreover, discourse studies are often interested in looking at the inconsistencies, as well as consistencies, in individual accounts across a variety of contexts (Potter & Wetherell, 1987). Whilst the aim of my study was not to look at individual cases of variations in accounts, the report of the analyses appears to suggest that Derek’s accounts were consistent across the group discussion and interview context. A discussion on the

³¹ However, my notion of ‘natural’ here is a rather limited one (Speer, 2002): in my study data were collected from research participants who had provided informed consent, were aware of the recording and may consequently have modified their actions in a range of ways.

ethics of anonymity in Derek's case is presented in section 2.4. Information about the group is presented in Table 2 (p.146).

Prior to the group discussion, I had asked for each group member's permission to audio tape-record what was discussed. Following assurances that the tape would be anonymised³² all group members agreed to this. I also arranged for one of the group members to distribute consent forms at the beginning of the group discussion and audio tape-record the discussion for me, thus minimising my intrusiveness on the discussion (Appendix F). The discussion was transcribed in full and followed the same principles used for the interview transcriptions.

2.3.3 Analytical procedure for the interviews and group discussion

The analysis began by first building up a data file of all the discourses related to working with minorities that were generated in the talk³³ (Gilbert & Mulkay, 1984). As noted, I am particularly concerned with the discourses dealing with cultural competence. In examining the role of interpretative resources, the definitions of the interviewees and group members themselves are used as the main source from which to derive meaning. The focus is on the discursive strategies that the psychologists used in talking about work with minority ethnic clients, and the constructions they used for the evaluation of cultural competence (Wood & Kroger, 2000). I focused attention on the way in which the talk is organised, what discourses/repertoires are drawn upon, what is constructed in the talk,

³² Participants were identified by a pseudonym and the list linking these to the participants real names were kept locked in a separate cabinet.

³³ Analysis of the interview and group discussion were conducted separately, but followed the same procedure.

and how the talk is ‘worked up’ (Horton-Salway, 2001). I produced a template to guide my analysis of each interview and the group discussion, by putting together the suggestions for analysis from Gilbert and Mulkay (1984), Horton-Salway (2001) and Potter & Wetherell (1987) (Appendix G).

2.4 Ethics³⁴

Protecting the anonymity of participants in the group discussion required particular consideration. The group was quite small and it may be possible for some participants to recognise themselves and others. This was discussed thoroughly with all individuals prior to their participation in the study. I acknowledged the problems of reporting my analysis and findings in a confidential manner, and where a participant might be clearly identifiable I took the decision not to present large chunks of data at once (Flick, 2006).

I have applied pseudonyms consistently throughout the text, so that the psychologist Derek in the interviews will also be called Derek in the analysis of the group discussion. This is because this psychologist’s accounts were so similar in the interview and group discussion, it would have been immensely confusing if I had varied his name. As a result, there can be no doubt that those already familiar with him (in the group discussion) will know who Derek is. However, this was discussed with ‘Derek’ and, we agreed, that the other interviewees, as well as other potential readers, of this research are less likely to be able to identify him. Thus, we decided to not abandon using the same pseudonym. Moreover, it is my contention that the excerpts that I examine in subsequent

³⁴ It should also be noted that ethical approval for this study was gained from the Leicestershire, Northamptonshire and Rutland Research Ethics Committee, and the University of Leicester Psychology Research Ethics Committee (see Appendix H & I).

parts are not of interest as statement by 'Derek' or any other specific psychologist, but as instances of generic discursive repertoires which are regularly used by psychologists (Gilbert & Mulkay, 1984).

2.5 Validity and Reliability

Potter and Wetherell (1987) argue that validity can be significantly demonstrated if the analysis acknowledges contrary cases. It was precisely for this reason that I decided to identify a sample (those who work mainly with the White British population) that would enable me to take on board potentially contrary cases and therefore test and qualify my findings.

In terms of reliability, on the other hand, two qualifications ought to be made. Firstly, discourse analysis is interested in exploring an interpretation of discourse (Phillips & Hardy, 2002). This means that different people may interpret the same talk differently, depending on their context and background (Seale, 1998). It is precisely for this reason that discourse analysts encourage a reflexive exchange about the interpretative procedures and about the methods of analysis (Flick, 2006). As well as reflecting on my own impact on the research (section 6.2.1), I discussed my analysis in detail with a researcher experienced in discourse analysis from the University of Loughborough. This discussion strengthened my confidence in the interpretations that I was making and the methods that I had employed.

In the case of our second qualification, due to the labour-intensive nature of discourse analysis it can be productively applied to a few features of talk rather than the whole discourse material (Fairclough, 2003), it only allows some modest generalisations. Nonetheless, it is hoped that the multimodality employed in this study (Fincham, Scourfield & Langer, 2007) and the careful consideration to documenting my thinking and decision making (Flick, 2006) will increase the dependability of my data and procedures as well as increase confidence in the analysis (Hammersley, 1992).

Part 3

Study 1: Interview Analysis

The interviews provided a rich corpus of data, in which many different themes and topics were addressed and various arguments and interpretations presented. Here, the focus is on the presence of two overarching interpretative repertoires that were deployed in all of the interviews, which produced different evaluative accounts of working with minority ethnic clients: 'social context' and 'individual context'. My analysis will illustrate the interpretative variability within psychologists' discourse, by showing how the repertoire of social context is reappropriated and adapted to, the repertoire of individual context and, finally, re-worked in the construction of a client-centred and therapeutic framework for working with minorities. The discussion of this analysis will be presented in part 5, where it will be drawn together with the findings of the group discussion analysis.

It is important to note that when I concentrate on more than one excerpt at the same time, I present these excerpts jointly in a box. I have chosen to do this because it enables me to present and illustrate how similar or different versions in accounts are constructed. The key for identifying the boxed excerpts has two elements:

Box number: 1, 2, 3,...

Excerpt number: 1A, 1B, 1C...2A, 2B, 2C...

e.g. 2:2C

3.1 'Inward looking' Models and the Social/Wider Context Repertoire

It is perhaps appropriate to start the actual analysis with the arguments that turned my informants to a social/wider context related approach for work with minority ethnic clients. The short answer is that there is a preoccupation with critiquing 'inward looking' models common to both psychology and mental health on one hand, and broadening these models on the other. The latter is well illustrated in an excerpt from Rachel, in which she defines some of the aspects of her human rights model as inclusive of 'political, sociological and cultural' dimensions as 'bigger' than the 'normal models' 'taught on the course' (1:1A). The discursive device of interest is the 'extreme case formulation' in the use of the word 'bigger', reputed to be one of the most obvious words used to strengthen an argument (Pomerantz, 1986). Here, it certainly implies that the models taught on the (clinical psychology training) course are 'inward looking' and thus less comprehensive than her framework.

In contrast, another one of my informants invoked his membership to the profession of psychology to build an account that a psychologist's role is to offer alternative context related perspectives (1:1B). However, such membership entitlements are not 'natural' but need to be 'achieved' or 'worked up' (Potter, 1996). Here, this discursive strategy is achieved by defining the role of psychology as being other than 'biomedicine'.

Another informant, Paula, organised her account of 'inward looking' models around a narrative about psychological models becoming 'narrower' (Edwards, 1997) and employed the strategy of a three part list (Jefferson, 1990) to capture some of the features

of psychological models as, 'firm, clear and certain' and 'tight, identifiable and encapsulated' (1:1C). My informant proposed that such models are unhelpful because they may not describe/reflect the 'life experiences and heritage' of minorities.

In these three pieces of talk, my informants stress a social/wider contextual perspective in order to move away from the rather one-dimensional model of human experience, intrinsic to psychology. In view of a lack of minority context in existing models, a concern with minority clients' accounts of experiences and context has become a central one for the psychologists. This is the premise of the second overarching repertoire.

Box 1

1A

[Currently] I'm trying to adopt the human rights framework, which is looking not just at somebody's psychological problems, their political, their sociological and cultural, so it is bigger than I think the normal models that we were taught on the course. [Rachel, 172-175].

1B

I think there is a role for trying to understand people's context, which I think is our role, and it's a role not many people do in the NHS, because I think we just travel down a intrapsychic biomedical route and there is a role for questioning that and putting up different alternatives. [Derek, 429-434].

1C

(...) There just seems to be [a] narrowing of approaches so things have to be identifiable...entities...you have to do CAT or CBT therapy...it all has to be encapsulated, described in a very tight model and I think that's very unhelpful...and I

don't think those firm, clear, certain models, apply when you're working with people who have totally different life experiences and heritage from the authors of those models. [Paula, 478-487].

3.2 The Social Context through the Individual Context Repertoire

The crux of this repertoire is to comprehend the meaning of social contexts to individuals themselves. This is well illustrated by Paula who defines her practice as not assuming equivalence between, individual interpretations (of mental health) and their cultural interpretations/norms (2:2A). Similarly, Rachel reflects that understandings of mental health within cultures vary with personal and social experiences (2:2B). Both of these accounts stress that attention is actually on the level at which experience is interpreted, understood and made sense of by individuals themselves.

Box 2

2A

My practice is working from the position of the client, learning what is for that person healthy, that might incorporate aspects of cultural norms, but it would be very much derived from individuals' interpretation and observance of cultural norms. [Paula, 128-134].

2B

[Mental health in minority communities] is really individual and in one community, like in the Iranian community, you can get somebody who just has no concept of this and you can get somebody who's spent their whole life seeing a psychologist, so it is really different actually.

And it varies within the different communities depending on gender and class and all sorts of things. [Rachel, 106-110].

In these accounts, the construction of 'culture' is flexible enough to allow for a degree of variation in the way in which it is embraced and thus is constructed in de-essentialist terms (Barker & Galasiński, 2001). There are also various examples in my informants' accounts, however, where cultural essentialism is present.

3.2.1 An essentialist repertoire in dealing with individual and group beliefs

We can draw upon two further excerpts from Paula and Rachel to show the discursive construction of essentialist notions of minority group cultural beliefs (3:3A & 3:3B).

Box 3

3A

With a lot of the Muslim communities I think I would be perceived as not necessarily knowledgeable about what it means to be Muslim...there's this sort of conceptual distance that would be assumed, that I think there has to be negotiation over. (...) I try to open up that kind of dialogue with people about, for you, in terms of your faith, what/how does this situation that you're in reflect in terms of your faith beliefs...but I know that I'm really not very knowledgeable...and I have struggled with working with some people who have specific positions, which I know that I don't understand and I can't really make sense of in my conceptual world. [Paula, 163-177].

3B

There are quite a few young people who have been trafficked over here and one of the things that they've been led to believe by the smugglers that bring them over here, is lots of witchcraft, you

know if you talk to anybody bad things will happen, and we think [the idea of witchcraft] is a very good technique to keep children silent, but then that's a belief that they've got and actually it's really quite hard to challenge. ..because it's underpinned in a cultural belief and then for you to say well actually that doesn't exist and for you to be the person that judges whether or not something is helpful, I think it is really difficult actually. [Rachel, 129-144].

In excerpt 3:3A, the implications of Paula's choice of the terms 'Muslim communities' and 'Muslim' work up generalised categories that are likely to bear on essentialist notions of Muslim identity. Such categories are called into play to 'script' (Edwards, 1997) how a conceptual distance when working with Muslims, in this particular case, is expected or 'assumed'. Yet Paula does not provide detail of who is doing the 'assuming': it could be the client or Paula or both. The discursive strategy of 'generic vagueness' enables her to avoid giving details about her assumptions (Potter, 1997).

Agency and accountability are particularly noteworthy in this excerpt (Edwards & Potter, 1992). Paula assigns herself as 'trying to open up the dialogue' that tackling conceptual distance requires and thus the, positive, act of 'negotiation' is accountable to her.

However, dialogue/negotiation is produced in so far as Paula is 'knowledgeable' about the belief and the belief can be made sense of in her 'conceptual world'. Thus, her agency is limited. However, the limitation is described as more than a product of just *her* lack of knowledge, it is also the result of her being '*perceived* as not necessarily knowledgeable' and therefore, potentially, somewhat knowledgeable. The categories of 'some people' and 'specific positions' are not elaborated upon, which perhaps gives Paula the opportunity to assign conceptual distance to the generically vague category of

‘some people’ with ‘specific positions’, without having questioned her conceptual framework’s status (Verkuyten, 2005). Overall, agency and accountability work to exonerate a lack of knowledge and conceptual distance (Edwards & Potter, 1992).

In excerpt 3:3B, there is a dilemma of questioning the legitimacy of a potential cultural belief. Initially, ‘witchcraft’ is constructed as something that ‘young people are *led* to believe’, which clearly questions the very legitimacy of witchcraft as a cultural belief. However, the questionability is counter-acted by distinguishing witchcraft as a ‘belief that they’ve *got*’. Finally, Witchcraft is constructed as a belief that is associated with ‘culture’ and thus ‘really hard to challenge’. The variability in constructions goes hand-in-hand with a shift in positions. Firstly, my informant talks from the position of ‘we’ to describe a collective concern with what child traffickers *do* with the notion of witchcraft; therefore, rather than seeing it as a belief it is seen as a ‘technique’ for making children compliant. Here, the use of ‘we’ is a common discursive device to shore up accounts (Dickerson, 1997). At the same time, however, it is seen as ‘underpinned’ in a cultural belief. Variability is extended by moving from a position of ‘challenging’ the belief to deconstructing its ‘existence’, and, finally, to being in a position to ‘judge’ it.

These sequences of variability are important because they highlight that working with individual interpretations and understandings is itself less coherent than commonly assumed. This is particularly well illustrated by one of my informant’s discussion on the importance of religious beliefs to how minorities may construct their experience; here, religious beliefs are presented as both malleable and rigid:

Inter. Would you be looking at alternative perspectives interpretations within the religion, to beliefs about punishment say?

Ruth. Yes we would help them to think about what the alternatives would be or what else their religion might say about this, basically what else could be said about this situation or this problem... I think just being aware that it's far more complex often then just one single way and one single set of rules, but at the same time you know you can't *override* them really, you have to *tread very carefully* because you're not in a position of actually being a religious mentor or something like that for this person, and so you have to get the balance right between *suggesting alternatives* or trying to *take over their belief system*, say this is how you should be operating as a Christian or Muslim or whatever. [My emphasis, Ruth, 199-212].

I will paraphrase Ruth to show how this malleability/rigidity is worked up; she argues that the psychologist can help the client find various contextual accommodations in religious beliefs so that a more helpful strategy or understanding can be found. However, it is important to note that 'alternative perspectives' are never neutral, but versions of 'reality', constructed by speakers in a particular context (Horton-Salway, 2001). This is to some extent recognised by Ruth, as she argues that in seeking to find alternative 'ways' within the religious framework, the psychologist has to be careful not to 'override the cultural belief'. By using the word 'override', cultural beliefs are described in such a way that they appear as insurmountable or as being held steadfast by some minorities. In addition, the rather cautionary remark of needing to 'tread very carefully' around beliefs that can not be 'overridden', stands in contrast to the idea that beliefs are malleable. The idea of psychologists operating with a dualistic or an essentialist/de-essentialist view, in which minority cultural beliefs are considered to be both flexible and mutually exclusive, supports the discourse analytical premise that the interpretative repertoires at any individual's disposal cannot be restricted to any one set of ideas (Gilbert & Mulkay, 1984). Whilst variability within and across accounts may lead us to assume that

conceptualisations are worked up as distinct and separate, my informants' discussion on psychological work with asylum seekers was particularly illuminating on how separate repertoires are worked up to discursively achieve the same model/framework for working with minorities. I will now turn to these repertoires.

3.3 Three Repertoires Concerned with Managing Psychological Work with Asylum Seekers

In the process of talking about psychology and asylum seekers, the informants of my research adopted one of three repertoires: a lack of fit with mainstream services; a neglect of the wider social context; and, avoiding the categorisation/reification of minorities.

3.3.1 A repertoire about asylum seeker work and mainstream psychology services

In this repertoire the focus is on the tendency to treat work with minority ethnic groups as distinct from mainstream services/psychology. In the following excerpt the 'work' being referred to is practical case work with asylum seekers, involving support such as practical (housing) and political/legal (for an asylum claim):

There is quite a disparity really quite a range of opinions within our team about whether we should be doing that kind of work at all or whether it's our core business, whether it should be kept very separate. [331-333]. (...) Conceptually [doing practical case work] does [fit] to a degree, but... from where I'm at in my career, I've been at a certain level for a long time, and if I want to move into more managerial world and from that more managerial perspective there's a different slant on to what extent it's appropriate for services to be trying to meet these needs. [Paula, 381-391].

The first thing to note is the use of the pronoun 'we' in constructing the 'disparity of opinions' as a joint production (Goffman, 1981). In doing so, Paula's views or version of the team debates are avoided. Alternatively, this could be how Paula manages the risk of having her view/version discounted by the interviewer (Horton-Salway, 2001). In interviews, informants manage such risk by means of a device that Potter (1996, p. 125) has termed 'stake inoculation'. I will show how this works. The remark that 'conceptually' doing practical case work seems appropriate signals to the listener, in this case the interviewer, that Paula has a clinical interest in recognising this type of work. However, later she makes a statement about the managerial world/perspective, which may require her to take on board a different 'slant'. The 'stake inoculation' of 'conceptual fit', works to counter the possible suggestion that Paula is someone who does not recognise this type of work with asylum seekers as relevant to psychology.

Paula's account of a range of opinions within the team on how to categorise work with asylum seekers and the provision of details about the managerial world/perspective helps, to *constitute* the factual and authentic nature of her 'lack of fit with mainstream services repertoire'. However, the fact that her view is almost completely absent suggests that her position or footing in relation to this repertoire may also be ambiguous for her (Goffman, 1981; Horton-Salway, 2001).

3.3.2 A repertoire about psychologists engaging with the social context of asylum seekers

On the one hand work with asylum seekers provides a range of opportunities to engage with the social context of mental health problems experienced by this client group. On

the other hand these very qualities seem to make psychological attempts to work with this group contestable. The resistance to taking on board the wider context was equated with the pathologising of asylum seekers:

I think that the whole thing about saying that all refugees and asylum seekers should go to trauma centres is really inappropriate because actually it's not just about trauma, it's about loss, it's about exile, it's about persecution, it's practical, it's political - it seems so wrong to put everybody in a trauma centre. It pathologises people as well, it puts the problem in them...all this focus on [psychological] treatment and sorting people out ignores the cause of people's problems and the cause of them is human rights violations and abuses...let's focus on the cause of it. [Rachel, 598-608].

Rachel's account is, of course, extremely compelling and it gives us clear details of some of the circumstances and events of trauma. Without this sort of 'organisation of description' (Edwards, 1997) her account would fail in its 'attributional business'³⁵ (Horton-Salway, 2001). In other words, it would take the special effort of objecting to or rejecting a series of wider factors framing asylum seeker issues, in order to avoid taking on board a social perspective and endorse the 'inward looking' perspective as valid for this type of work.

3.3.3 A repertoire about avoiding the categorisation/reification of minorities

At several places in all of the interviews, reference to a dilemma between having specific services or approaches for minorities and the distinctions that this makes from

³⁵ i.e. what Rachel achieves by assigning particular causes to trauma and what she is doing with this causal attribution in her description of psychology.

mainstream services/approaches was made. Box 4 contains extracts that are two examples.

Box 4

4A

I do think you run the risk, of having [a] particular module on cultural issues, to make it a separate thing from the human being that you're seeing and I know early on in my career I was thinking oh right I need to read up on what Sikh people, what Muslim people do, and I never had that about Catholics or Protestants...so you run the risk of categorising people even more. But, also knowing that people aren't accessing the services anyway. So there must be something fundamentally wrong or that...it's not the kind of service that they want. It's not what they want anyway, but they'd probably access something else if it was more appropriate to what was culturally acceptable. So it is a risk, so there's no easy answer to that...I think it might be a bit of both. [Sarah, 175-194].

4B

[With specific cultural services] are we then getting into prescribing of services, that if you are this particular ethnicity then you should go to this particular service, so are we closing down choice through that. (...) I think siphoning off services also siphons off interest and siphons off workers who have a richer ethnic experience that's then lost to the mainstream services. [Derek, 349-372].

In extract 4:4A, using the distinction of Sikh/Muslim and Catholic/Protestant, Sarah draws a contrast between categories of religious groups. Drawing contrasting categorical distinctions is a useful means of accomplishing discursive goals (Dickerson, 2000; Edwards, 1997). On the one hand are those that working with 'would' require 'new' knowledge to understand what they 'do'. On the other hand are those who 'would' be

assumed to 'do' things in partly familiar ways. Sarah specifies that by having a culturally specific module there is 'even more categorisation' because, it establishes 'separateness' and diminishes the 'human' characteristics that are shared. The extreme case formulation in the use of the words 'even more' is significant in that it implies that these groups are already categorised in some way (Pomerantz, 1986). Using the familiar discourse marker of 'but' gives Sarah the opportunity to present the other side of the coin: 'people aren't accessing the services anyway' (Schiffrin, 1987). Sarah refers to a variety of possible reasons for this: there is 'something fundamentally wrong', 'it's not the kind of service that they want', and 'it's not what they want anyway'. Her overall construction, however, appears to be that minorities would 'probably access' some type of service 'if it was more culturally acceptable'. The proposition or assumption is thus that services are not 'culturally acceptable'. Hence, the earlier postulation of teaching on cultural issues creating a 'risk' of further categorisation is levelled with a 'risk' of services being 'culturally unacceptable', if knowledge on cultural issues is absent.

Contrastingly, in excerpt 4:4A, Derek suggests that culturally specific services create separateness, in that minority needs, services and workers are pigeonholed. A minority client's needs may be defined in terms of ethnicity in a more or less assumed way, and knowledge from these services may not infuse into other organisational settings.

Overall, talk about culturally specific services/knowledge functioned in an oppositional way: either making separate services necessary or inducing separateness and reification. These accounts indicate that my informants were undecided about the use of cultural

competence models; however, it is worth examining the actual argument against these models. Such an examination will give an indication of how and in what way my informants construct an alternative approach to working with minorities.

3.4 A Repertoire on Cultural Competence and its Reformulation

In the interviews, there were various examples where cultural competence models were critiqued and rejected, the following excerpt is an example:

I don't think much of [cultural competence models] because it's rare to find one that seems really helpful, they can be really superficial and you just think what difference does that make to the person coming in through the door? It's rare that they actually get into the detail of what goes on in the one-to-one situation in therapy. [Ruth, 263-275].

In Ruth's account, cultural competence models are presented as not informative or rich about minority ethnic clients and not particularly potent to minorities themselves. The criticism, achieved here, is consequential because it involves a claim that the models should be getting 'into the detail of what goes on in the one-to-one situation in therapy'. The therapeutic context did play a role in the psychologists' construction of a framework for working with minorities. The following excerpt is one example:

Well it's about respect at the end of the day, for another human being and respect for the similarities and differences that you have with that person, in the room if you like, or the family that you're facing. And to me that was lacking anyway. And I often felt that I'd come onto the wrong course almost, because I was expecting to learn to be a good

clinician/therapist, but that that was almost absent. And to be a nice person doesn't seem to be in vogue at the moment. So that's where I'm coming from at the end of the day, I'd like to be sensitive to whoever I was sitting in front of and respecting that some things might be more important to them than me and just being aware of it and being able to discuss it with them. [Sarah, 158-170].

In this excerpt there is a clear link between a therapeutic/humanity orientation and clinical practice. In the interview discussions there are examples where therapeutic qualities are presented as a more or less central way of working with minorities: the resulting principles were 'respect', 'equality and engagement in the therapeutic relationship', and 'building trust'. The equation between therapeutic principles and a framework for working with minorities is not simply stated, however, but made acceptable and factual. In the above excerpt, Sarah does this by introducing the framework as very obvious ('well it's about respect at the end of the day'), by giving concrete and detailed examples (e.g. 'for another human being', 'respect for the similarities and differences' – with the person in the room or the family being seen), by positioning her framework as very ordinary or at the level of core basic characteristics (being respectful, a good therapist and a nice person) (Sacks, 1992), and by demonstrating her consideration of difference by describing her sensitivity/awareness ('respecting that some things might be more important to them than me') (Edwards, 1997). The framework is described in such a way that it appears as both ordinary and, crucially, fundamental and is therefore difficult to critique. An example of this type of therapeutic framework from another informant, however, is more contentious:

People's expression of themselves in [forensic] settings was often misinterpreted...just how people spoke to each other in general and how exuberant they might be I think was misinterpreted a lot...their humour and their outgoingness and how they viewed life was very different and I think that is misinterpreted - [a] *lack of client centredness*. [My emphasis, Derek, 256-278].

In this excerpt, the misinterpretation is presented as a 'lack of client centredness', placing it thus in a therapeutic context, rather than in a broader context of ethnic differences. As such, it could be read as either overlooking ethnic discrimination or not overemphasising ethnic differences. For example, the differences in communication/behaviour are described in such a way that they appear as ordinary and thus not paid attention to. However, the differences clearly have implications for the clients: their communication/behaviour is misinterpreted. On the other hand, by constructing the misinterpretation as a lack of client centredness, it forms part of a core and general concern with the lack of therapeutic context or (human) rights for the client, that does not mitigate whatever subsequent layers of other inequalities the client may have experienced. Although there are many possible ways of understanding discrimination and inequality, a more human rights framework was used by my informants. Therapeutic and humanity oriented values are presented as the framework of practice with minority ethnic clients, because it was seen to be contextually equally meaningful to all members of the population and available to all psychologists in all areas of practice. However, the final excerpt to be addressed here seems to suggest that there may also be an element of trying to take out psychology from the equation:

I think you have to work within that person's belief systems and therapy does push often down to changing people to a normal subset of beliefs and behaviour, when actually I think sometimes that's unhelpful, and within psychosis that's, you know the majority of treatment packages around are about changing beliefs rather than actually saying well how do you live with that believe in a society where it doesn't quite fit, often, so I think we just need to be quite wary really on what we think we're achieving and exporting to people [Derek, 405-4130.

This excerpt may reflect the concern of anti-humanism addressed by the other psychologists. For example, Derek questions the ethical assumptions that accompany the increasingly popular cognitive models by identifying their problematic underlying nature, that beliefs should be challenged and changed to fit in with the society within which they operate. This excerpt thus contributes to the 'humanism/therapeutic' turn, seeing them as not only 'working within the person's belief system' but also as a way of countering the charge of cognitive dominance frequently leveled against psychology.

In summary, this analysis has developed two key discourses. First, in the oscillation between the social and individual context repertoires is the argument that rather than being services/models which aid understanding, sensitivity and wider awareness, culturally specific services provision and models may in fact be an agent of the essentialising of minorities, representing as they do the pervasive focus on difference. Second, that a therapeutic/client-centred version of working with minorities can make sense of contextual experience and understanding, and, importantly, such a framework also minimises the spread of cognitive paradigms.

Part 4

Study 2: Group Discussion Analysis

The data for this analysis were obtained from a ‘natural’ discussion amongst clinical psychologists in an adult mental health context. The discussion on ways of working with minority ethnic clients was lengthy and complex and I therefore have to be highly selective in what is but a brief overview of some particularly relevant arguments and the insights that they have generated. The analysis presented here will illustrate that the diversity discourse articulated by the psychologists in the group discussion is discursively less ‘cultural’ than assumed by the group members. Essentially this is, as will be shown, due to how an individual repertoire is used and justified.

4.1 A Repertoire about an Individual/Curious Psychological Framework

Some of the group members defined working with minorities in terms of an individual and/or curious approach to formulation. In this part of the discussion different forms of examples and arguments were used by two of the group members to ‘work up’ a non-culturally specific model for working with minorities. Three examples/arguments will be considered: a formulation based repertoire; a curious/ubiquitous based repertoire; and a repertoire that works to corroborate the former two repertoires.

4.1.1 Repertoire on formulation as individual and not cultural

The first excerpt is taken from a context where the participants discussed diversity in terms of training and the acceptability of not using culturally specific frameworks for different cultural groups:

(1) we had a woman from the States and her take was more an individual approach to it, saying as a psychologist you will see individuals and the best way to deal with that is just find out about that individual in their context. Therefore her line was less about you need to know this about these different ethnic minority groups and more well, we work in a formulation based profession where whoever is sitting in front of you will have potentially numerous different experiences...I don't think about numbers of ethnic minority in our case loads, it's not a topic that I've got involved in, it's not something that I particularly think about and may be that is partly because as a psychologist I take this formulation based approach. [Derek, 40-54].

The first thing to note in this excerpt is the way in which Derek corroborates his account by citing 'someone' else as advocating the view (Dickerson, 1997), and how her view is made acceptable and factual by using the extreme case terms of 'less' and 'more' (Pomerantz, 1986). The individual approach is accomplished in a rhetorical context (Billig, 1987), which also does attributional work with respect to Derek's minimal concern with ethnicity and the reasons for that (Horton-Salway, 2001). Derek does this by introducing his description in a specific order: beginning with 'her' evaluation that it is less about needing to know something specific about different groups and more about the formulation approach, before revealing that the person being seen will have numerous experiences (Edwards, 1997). The organisation of description is important because 'numerous experiences' necessarily implies that the psychologist cannot learn about every potential experience and thus the 'needing to know less about specific things' is made acceptable. Derek's joint account ('we') of working 'in a formulation based profession' is in the middle of the two propositions, implying that it can link them

together: since there is no bottom-line to experience there is no bottom-line to knowledge, therefore all we can do is formulate experience from what clients' tell us about their experience. The assertions that he does not think about ethnicity are described as a result of the particular formulation approach. There are two discursive strategies noteworthy here. First, Derek speaks from the footing of 'a psychologist', which functions to give credibility to his position and counter the possible suggestion that Derek is someone who personally does not think about ethnicity (Goffman, 1981). Second, the individual formulation approach has been presented by Derek as primarily someone else's argument and thus works to counter any criticism that may be placed upon him.

4.1.2 Repertoire on formulation as curious/ubiquitous

A second example of the individual approach is where another group member argues that psychological formulation 'is about being curious with people...it's just about asking the individual' [Tim, 75-76], he further describes it as:

(2) A universal or ubiquitous approach which would be just a bit more about willing to learn and find out from people, now clearly there are people that are unwell maybe they're not in a position either to say or whatever, so that might make it more difficult at times. [Tim, 146-150].

In this excerpt the individual approach of 'learning and finding out' from the person themselves emphasises client-centredness. His concern with client centredness is demonstrated by correcting himself in recognising that some people may not be able to express themselves (Edwards & Potter, 1992).

Nonetheless, the equation of individual formulation and client talk on ethnic and other background experiences is presented as self-evident and inevitable in Derek and Tim's accounts. In both accounts there are examples where the individual/curious approach is presented as routine in psychological work. However, if the psychologist does not have knowledge and thus awareness about culturally specific issues/factors the opportunity for a culturally-relevant discussion taking place is mainly, if not totally, the responsibility of the client.

4.1.3 A Repertoire building consensus and corroboration of the individual framework

The equation of individual/curious formulation and client expression was clearly the repertoire that Derek and Tim most often engaged in. There are also various examples in the discussion where joint construction functions to build consensus and corroboration into the repertoire (Horton-Salway, 2001). This is particularly evident in a part of the discussion that focused on Derek's psychological work with a 'mixed race' client who had experienced some bullying as a child (it is worth quoting in full see Appendix J). The account begins with background information: including the client's difficulties; the description that he was 'teasing apart' complexity; and that the client 'was not an amazingly open person'. The detail in his account is constructed in a way that makes his involvement more authentic and plausible (Potter, 1996) and the client's temperament as likely to have a negative bearing on his complex task (Edwards and Potter, 1992). Derek further manages his personal accountability by working up reflections on the situation and his errors of judgement, hence, anticipating and dissolving the potential for criticism (Potter & Wetherell, 1987; Wetherell & Potter, 1992).

Derek then gives a factual statement from the client and a re-wording of the statement by himself. Positioned against a request to recall some of the hostile responses that the client received as a child, she responds by saying 'I don't want to talk about it' [171-172]. The statement was interpreted by Derek as, 'fuck off don't ask me about that' [177]. Whilst authenticity in Derek's account is increased by citing 'actual' conversations (Hutchby & Wooffitt, 1998), owing to the fact that we can never know if the words were said as 'fuck off', the account is less authentic.

If we take on board the hostile sense of the client's statement along with her 'not very open' persona it generates a negative identity; in comparison, Derek works up an identity as helpful, reflective and open:

(3) It felt as though I was just kind of pretty clumsy, but that might not have been, it might have been that I was challenging open and honest, and asking because I thought it's useful for me to know the extent of this, you know does it link with the voices that she might be hearing or whatever, but it kind of all felt a bit difficult and uncomfortable. [182-187].

In response to this account, Tim exonerates Derek's clumsiness 'it didn't sound that clumsy when you said it' [193-194]. In addition, Tim's description of a similar case helps to constitute Derek's *non*-clumsiness:

(4) somebody I saw is from mixed race...and I think I asked something quite similar at a similar sort of stage, again being around bullied and so on, maybe called names...to do with his race and ethnic sort of background and I learnt quite a lot, because I'd sort of asked a

similar thing at a similar time and everything and it was really, I felt it seemed appropriate, and the client seemed comfortable with it, and actually I learnt quite a lot...

Derek. *He was a bit more open about it.*

Tim. Yeah, and equally that then did leave quite a lot of room open for discussion. But I can't imagine that I was anymore sensitive or you know thoughtful than you, in the way you asked it. [My emphasis, 195-209].

This account works to give some assurance that their 'questioning' is not problematic or unhelpful, but consistent in action and thus valid in their approach. Also, Derek interrupts Tim to say that the client 'was a bit more open', which helps to attribute the difference between client responses in the two cases to a characteristic (open/not open) of the client. A consideration of how 'learning and finding out' about client's issues can only be pursued if the client has resource or opportunity within the therapeutic context, to bring forward these issues, is absent.

From the above repertoires we encounter a very general framework on formulation, one that is designed to address all people ('universal'). There are also various examples in the discussion, however, where the individual approach is explicitly and/or implicitly criticised and rejected. These repertoires were presented in terms of: a consideration of the psychologist's cultural background; a consideration of the cultural knowledge in mental health services and the wider staff context; and, finally a consideration of what the individual approach is not inclusive of.

4.2 Repertoires that Challenge the Individual/Curious Framework

4.2.1 *A repertoire about the usefulness of reflecting on the culture of psychology*

The following excerpt is taken from a group member who responded to Derek and Tim's argument that a general individual/curious approach is appropriate for working with minorities:

(5) No, yeah, I was just thinking about some of the things we [were] talking about, part of formulating what's happened to the client, and, but part of me is also thinking, the key bit for me is not necessarily knowing about different ethnic groups because you're never going to know about all ethnic groups so it is about being curious, but partly, for me, it is about reflecting upon your own cultural heritage and being aware that actually other people have different perspectives and actually that the psychology that we practice is just embedded in a Western culture...so for me it's more about being reflective upon yourself... so for me its more about reflection for the psychologist rather than needing a vast amount of information, that's just me, and also yeah, I don't know that's my kind of take on it. [Faris, 86-101].

The first thing that can be noted in this excerpt is the initial hesitation as well as false start at the end of the excerpt that are typical of talk about difficult and sensitive topics (Condor, 2000; van Dijk, 1984). Faris makes obvious his relationship to the views that he reports, by using terms and phrases such as 'part of me', 'that's just me' and 'that's my kind of take on it' (Goffman, 1981). The fact that he starts by indicating that he does not disagree with the group members' views seems to suggest that he is struggling, on the one hand, with the need to show reflection on the discourse of other group members, and,

on the other hand, wanting to argue for a more reflective approach. He highlights that thinking about diversity is not just about ‘knowledge’ on various groups, but is also about the culture that psychology has absorbed and the psychologist has internalised. From this view, the argument that knowledge on all cultural groups is not possible is just one side of the coin: the other side is that culture/diversity can be drawn upon by the psychologist to reflect upon their customary ways of thinking. Thus, a culturally oriented approach has other qualities and benefits that should not be dismissed.

4.2.2 A repertoire looking at the culture of mental health services/professionals

In the discussion one participant argued that cultural issues would not receive special attention, if any, in the wider mental health and staff context because he described such contexts as dominated by a ‘biological’ or ‘inward looking’ framework [Tim, 275-282]. Another participant reacts to this claim by explaining a lack of attention in terms of a lack of knowledge/awareness:

(6) But do [staff] see it as not relevant because they don’t understand, if you don’t know about something you wouldn’t see it as relevant, if you’re ignorant of a cultural aspects of things then you wouldn’t see it as relevant because you wouldn’t even think about that, you wouldn’t be asking those questions would you, in yourself. [Hannah, 283-286].

This excerpt is exceptional in the inextricable link it works up between a lack of knowledge on culture and ‘ignorance’ of cultural issues. The possibility of not having to learn about cultural issues is explicitly rejected. Hannah goes on to suggest that wider reflection could manifest itself through asking ‘what is our cultural identity’ and ‘what is

our culture' [292-295]. This type of questioning is important because it has the potential to counter the way in which ethnicity is usually associated with minorities, as though the majority group stands for a universality rather than its own ethnic/cultural specificity (Fredman, 2001). Faris describes it as:

(7)If you're within that majority ethnic group you don't think about yourself as having a cultural identity because it's there all the time, its subsumed [296-298].

This discourse was used by Faris to argue that because the majority group's ethnicity is automatically acknowledged they tend not to think a great deal about ethnicity/culture, and consequently more minority ethnic members take up the lead in these issues [308-310, 323-324].

4.2.3 A repertoire identifying the limitations of the individual approach

Some interest in the limitations of the curiosity/individual repertoire was considered by Tim and Derek:

(8)Whether that's sufficient though to ask on an individual basis at times or whether there are bigger issues, I mean for instance we've never really spent any time thinking about the lack of access that people from black and minority ethnic groups to psychology in general, it's kind of a well known fact and everything, but we as a group haven't particularly done anything about it...But at the same time I don't think we should beat ourselves over the head either. [Tim, 77-85].

(9) I suppose that the limits of just asking the individual...it means that tangible things like we haven't looked at our case load, in six years, as to our ethnic minority mix on it, and the interest or the inclination to look at it further. It limits that broader picture that might be more informed commented on. [Derek, 221-228].

As can be seen in the two excerpts above, the participants agreed that the individual approach does not incorporate a 'bigger'/'broader' picture. The notable thing in excerpt 8 is that the confessional statement of not doing 'anything about' the lack of access to psychology services by minorities, is presented as less problematic by the statement 'I don't think we should beat ourselves over the head either'. Excerpt 9 makes it more clear that under the aegis of the individual approach the psychologists are more inclined to avoid considering their service and other wider dimensions.

Further lines of arguments were presented, by Tim and Derek, in which thinking about ethnicity was presented as a kind of essentialism and separateness. An example is the following excerpt:

(10) I think things get hived off, we have the Asian worker, we have the lesbian, gay and bisexual issues worker, whatever it might be, and things get hived off...and you get the kind of enclaves of different specialist interest and maybe I think that's the good point about if we were to think more broadly about diversity and difference we can all kind of relate to that a bit more. I mean because [there are] massive differences between all of us and our clients, based usually on class, housing and all those kind of things, which might put huge barriers in

the way...but I'm sometimes a bit more damp about the hiving off into kind of sub-areas of diversity that then we don't really need to think about it. [346-362].

There are two lines of argument here. On the one hand, there is the practical concern for not emphasising a specific aspect of diversity so that interest/relevance is not sectioned off. If all potential diversities were separated and handled by different workers/services, they would lose their relevance to the mainstream worker/service. On the other hand, thinking broadly about diversity/difference, as opposed to specific diversity issues, is presented as a better way of enabling the psychologist to relate to diversity. The emphasis is more on the consequences of focusing on a specific diversity and not on cultural knowledge not being needed. Separate services/workers are equated with 'hiving-off' interest, making the issues less relevant to the mainstream service/worker. The assumption appears to be that getting rid of specialist services will somehow make diversity relevant to the mainstream. However, the focus on a non-culturally specific formulation/knowledge has not been dissolved and thus undermines Derek's account about the possibility for mainstream services/workers to adopt an interest in diversity or acknowledge its relevance.

To summarise very briefly, as what follows is the discussion, there has been an emphasis on demonstrating that working with minorities does not require specialist approaches or activities, because the psychological approach 'naturally' presents and represents a particularly well suited method (i.e. the individual/curious) for delivery to clients from all cultural backgrounds. Whilst this type of discourse was not shared by all group members, it nevertheless was the dominant discourse in my analysis of the discussion.

Part 5

Making Sense of Psychologists' Discourse on Working with Minority Ethnic Clients

5.1 Discussion

The present research examined some of the discursive repertoires and devices used by psychologists in talk on working with minorities/diversity. The focus was on how psychologists formulate and negotiate their work with minorities and through this a consideration of their constructions of cultural competence. Two studies were conducted: the first study was based on interviews, and identified the interpretative repertoires of 'social context' and 'individual context' that were used by the informants to construct particular versions of working with minorities. The repertoire that the social context and background of minorities needs to be included in work with minorities was reappropriated to an individual context repertoire; attention was thus focused on the level at which the wider social context is interpreted, understood and made sense of by individual clients.

When psychologists drew attention to individual interpretations, the understandings that were underpinned in cultural/religious beliefs seemed to lead to an interesting dynamic between questioning the interpretation and not challenging the interpretation. This was particularly evident in one of my informant's accounts of 'witchcraft', which was variously constructed as either a cultural belief held by some young people or as something that they may have been led to believe in the context of child trafficking. The

idea that some cultural beliefs cannot be challenged does seem to adhere to essentialist principles. For the interviewees themselves, however, the main problem is in questioning a client's belief when it is supported by a wider belief system, cultural or religious. This thesis stands in exceptional contrast to the modern *zeitgeist* of psychology in the challenging of individual beliefs under the practice of cognitive models, which resonates with the point of departure for their social repertoire, in line with other authors (Almeida, 2003; 2005; Boyd-Franklin & Hafer Bry, 2000; Burman, Gowrisunkur & Walker, 2003; Chantler, 2005; Mahtani, 2003; Nippoda, 2003; Patel, 2003; Thomas, 2004; Weine et al. 2006). It is interesting that most of the psychologists did not stress the significance of this and the emphasis remained tied to an oscillation in repertoires of malleable and rigid cultural beliefs, and repertoires of social context related work and individual context related work.

The discursive application of these repertoires was stressed in the arguments concerning whether socially complex broader work with asylum seekers is fitting with psychology, and whether culturally specific services to work with this group emphasises differences and distinctions. Whilst the notions of client-centredness and humanity may challenge the focus on differences and thus avoid the well-worn tendencies of ethnocentrism, they are contested notions. For example, Korchin (1980) has argued that such liberal ideological notions, adopted by psychology as an impartial way of relating to the essential humanity in each client, has meant that psychology has not been sufficiently concerned with diversity and mental health. Equally then, it does not follow that therapeutic and client centred concepts are not 'localised' or 'culturally bound'; a liberal

ideology is destined to have particular interpretations of ‘humanity’, such as autonomy (McNamee & Gergen, 1992). The implications of therapeutic/client centred models for working with minorities are, that as well as establishing more humane considerations for practice they may assume Western (‘liberal’) considerations of individual experience and understanding.

A non-culturally specific approach may also reduce the concern for, and attention on, problems of ethnic discrimination in mental health services, as well as racism and mental health (Barrett & George, 2005; Halsey & Patel, 2003; Nadirshaw, 1992). In the client-centered/humanity discourse, however, my informants highlighted that it is easy to use notions about culturally specific issues and knowledge to automatically adjudge and classify minority groups as different. Employing a therapeutic context-sensitive approach is not to suggest that ethnicity is a problem or that ethnic discrimination is not a problem: rather that, services/approaches based on culture or ethnicity may create an *unnecessary* distance from the idea of equality, because they are not based on the core fact of being a human being. For instance, the various models of cultural competence that have been published in clinical psychology might have been developed for working specifically with minorities, but equally classify as belonging to competent practice with any client³⁶. The point is that culture or ethnicity should not need to be used as a tool or resource for minorities to receive the same treatment and services as non-minorities. In agreement with multicultural notions (Gutmann, 1992; Waltzer, 1983), but not with all of my

³⁶ Some cultural competence principles are presented in Appendix K, so that the reader can assess whether the principles are significantly minority-specific.

informants, services and approaches that would meet the uniqueness of their culturally distinct practices and beliefs are tantamount to equality.

In the second study, the main repertoire is of an individual/curious approach to working with minorities, which aims not to single out ethnicity and culture, in a more or less automatic way when seeing a minority client, but rather to keep formulation open to various settings and contexts of relevance to the client. However, the discursive features employed to construct this repertoire suggest a much narrower focus. These consisted of professional definition and joint construction strategies, which assist in constituting a 'we discourse' (Goffman, 1981; Potter, 1996). This is illustrated in Derek's account of the individual formulation approach (1), where the 'we discourse' functions to deny personal responsibility of the individual formulation approach, and its displacement on to the group/profession as a whole, in the sense that what many psychologists believe cannot be wrong (Wodak, 1996a). In a similar vein, strategies of self-justification enable participants to make fundamental evaluations of the 'other' and to assign responsibility or blame to the 'others' (Wodak, 1996a). The workings of such a discourse of self-justification, which is closely wound up with the 'we discourse', is evident in Tim and Derek's joint construction of the client's lack of openness being the cause of difficulties in talk in therapy, which allowed Derek to present himself as free of blame or responsibility or even as a complete contrast to the client's alleged difficult presentation (section 4.1.3).

The individual/curious approach would not understand the settings/contexts of minorities, the other group members argued, because it denies taking on board knowledge and thus awareness about minority cultural backgrounds/issues. The other group members also provided arguments that, under this approach, the culture of the majority group members is not reflected upon and thus it is difficult to encourage psychologists and staff more widely to recognise the cultural aspects of minority experiences, as well as their own positions and approaches. These group members recognised that, consequently, it is mainly minority workers who take part in such reflections. The explicit absence of cultural knowledge, in this approach, means that the responsibility for a discussion of culture in therapy is placed squarely on the shoulders of the minority clients themselves (Kirmayer, 2003, p.168).

In response to these critiques and concerns, the individual/curious repertoire moves into a different array of discursive strategies, employed to express the same or similar argument concerned with not having culturally specific knowledge. The most significant example concerns the development of forms of de-essentialist discourse: the discourses of fragmenting diversity into specialist areas/services and thus sectioning off relevance and interest from the mainstream workers and services. This was illustrated in the excerpt that focused on the argument that culturally specific workers, as well as workers in other types of diversities, lead to diversities being 'hived-off' (10). Indeed, it certainly would be a terrible thing to categorise people into distinct and essential groups/workers/clients. Therefore, the allusion to de-essentialism works very well to make this argument compelling. However, what remains unquestioned in the account is, whether separate

services/workers/group categories are actually essentialising or whether they are an important means of trying to achieve appropriate and relevant services and thus equality (see Brubaker, Loveman & Stamatov, 2004; Modood, 1998; Neisser, 1987; Verkuyten, 2003). In turn, we must question whether giving up culturally specific services would in fact result in greater cultural sensitivity or awareness in both mainstream services and psychology. The fact that cultural knowledge is not a requirement in applying the individual/curious approach to minorities, however, narrows the possibility considerably (Stuart, 2004).

The interspersing of critique to the individual/curious repertoire means that there are, of course, divergent views and as a result, there are opposing interpretations of cultural competence. The repertoire that the individual/curious approach is capable of accessing a variety of settings and contexts was found to use arguments of individual psychological formulation and essentialism/de-essentialism, to define a general framework that can more or less be applied to any client (Pinderhughes, 1989; Wohl, 1989). In contrast, the opposing accounts took issue with a neglect of cultural knowledge/awareness and the potential implications or consequences for the client, wider staff and mental health setting, and for the psychologist themselves (Sue & Sue, 1999; 2003).

The variety and complexities of debates have been put into perspective by the data material and participants of this study, which illustrates that it is misleading to suggest that the discourse of clinical psychology is monolithic. Instead, it has shown that as a 'discourse' it is itself internally heterogeneous, comprising a number of different views

and ideas on which clinical psychologists draw. An awareness of the presence of various arguments within clinical psychology discourse(s) makes it difficult to take any one set of ideas as representing clinical psychology discourse on ways of working with minorities and cultural competence, in a static way.

In addition, my focus on the two repertoires of social context and individual context, in the first study, is in no way meant to imply that contemporary psychological practice, or indeed the culturally sensitive views held among psychologists, can be reduced to two repertoires, but only reflects my own choice and delineation of a field of study. The complexities of working culturally sensitively, with the diversity of views and backgrounds of psychologists, clearly reveal the impossibility of any one (research) account offering anything more than an analysis of a carefully selected and circumscribed topic. This means that as the (novice) researcher I needed to make choices concerning my approach and focus of attention, accompanied by an inevitable realisation that I can only aim to shed some light on one among a myriad of complex and interrelated aspects shaping work with minority groups at any one point in time. It is important to combine this awareness with a consideration of the potential weaknesses of my study; before doing so, however, I will conclude the results of the present two studies.

In the present research there has been a close and direct discussion of the appropriation and/or contestation of a culturally specific/social framework as well as a client-centred/individual framework. Overall, the therapeutic interpretative framework gives clinicians a humanitarian responsibility to take care of respect and equal rights, and to

identify practices that are essential to all clients, which can be best approached through a client-centred framework. In contrast, the interpretation of individual context, which is used when arguing for the social context, seems to struggle on the one hand with the need to question some less 'helpful' minority cultural beliefs/interpretations related to mental health, and, on the other hand, not wanting to challenge cultural beliefs. In addition, in the individual/curious interpretative framework the importance of individual formulation and the need to know about minority culture only as far as it comes through from the client is emphasised.

Arguing that individual client understandings and interpretations is the method of seeking inclusiveness of their culture and other backgrounds infers that knowledge of the wider context and cultural backgrounds are not a particular requirement for clinical practice with minorities. Consequently, in clinical practice there could be a gravitational pull in which minority cultural considerations come to be translated into, or generally viewed from, majority cultural considerations. However, if religious and cultural values and beliefs form the omnipresent background to minority client interpretation, understanding and experience of mental health, psychologists may clinically require knowledge of these in order to adhere to the client-centred or even the individual framework (Kirmayer, 2003). The entry of non-Western views into models of 'competence' does at least make it more possible for Western psychologists to appreciate the meaning (and force) which the various beliefs have for those who adhere to them (Swan, 2005). As such they need to be clinically both acknowledged and formulated, if only in the briefest possible terms. In response to the recent activity and interest in the teaching of cultural competence in

clinical practice³⁷ the findings of this research are particularly relevant to teaching on formulation with minority ethnic clients. A formulation based purely on a contextual framework, supported by either a therapeutic or individualistic argument may not actually be able to fulfil 'human rights', because it side steps the issues of addressing racism and ethnic discrimination. Nonetheless, the alternative framework of 'specialising' knowledge and practice as epitomised in cultural competence models, may lead us to concerns about reification. The discursive 'pendulum' has thus swung in both directions. Clinical practice can advance most productively by debating and conserving what is most useful about each framework and collaborating to synthesise these perspectives with other divergent and conflicting voices and thus keep the discourse going.

Nonetheless, it could be argued that learning about these debates or discourses may not help the trainee or qualified psychologist to confront these issues in practice. Of course in the therapeutic context material is much more messy than the repertoires teased out here would suggest. My research did not aim to be 'instructive' in terms of constructing a model of cultural competence or the 'best' way for working with minorities, rather my objective was to identify some key repertoires or constructions of cultural competence in my informants articulations of cultural competence that might act as the basis of further clinical discourse on cultural competence. Importantly, however, there is something to be learned for clinical practice. Two major problems mentioned in the discourses of the psychologists in this research about cultural competence models are first, cultural competence models may constrain practice unnecessarily and inappropriately, because

³⁷ For example, the clinical psychology training courses at the University of East London, University of Leicester, and the University of Sheffield.

‘culture’ as an all-purpose banner homogenises groups, and if we dig down deeper, we find that cultural groups can be very tangled things. Secondly and just as importantly, the ritualistic observation of these models may not give real equality to minority ethnic clients but actually increase the risk of inequality by blunting clinicians’ sensitivities to the individual specific issues which do arise. Therefore I am not sure that it is a good thing for clinicians, who intend, and are increasingly being required, to engage minorities in mental health services, to utilise cultural competence models. Whenever we find ourselves face-to-face with a client from a minority background it is whether we encourage and train clinicians to ‘de-valorise’ cultural differences or to ‘valorise’ cultural differences. It is a question that this research can not resolve. I think we have to discuss it through again.

5.2 Gaps and Future Research

This paper concludes with a consideration of the potential limitations of my research. This falls broadly into two main categories: a largely reflective discussion concerning my impact or intrusiveness on the research and a discussion on some of the limitations inherent in the type of discourse research carried out for this study.

5.2.1 My influence on the researcher

Discourse analytical methods are unavoidably reflexive because of the strong social constructionist epistemology employed, and therefore the researcher is challenged to retain sensitivity to her role in generating the data (Marcus, 1994). In eliciting accounts from interviewees, discourse analysts are concerned with how the situation surrounding

the account is being characterised and how the account is being occasioned (Horton-Salway, 2001). In my interview, the situation was characterised by my ethnic background (Kashmiri British) and occasioned by my questions on minority ethnicity and culture. This unavoidably constructs a particular framework for the interviewees' account, and the interviewees may have felt uncomfortable if, and when, their perspectives were different from what they assumed my perspective was. While I am not suggesting that informants refused to discuss certain areas with me on any such basis, it is likely that the ways in which their responses were framed were influenced by the way in which I was received. From a discourse analytical position, it would have been useful to explore how my own position has had a bearing on the data generated as well on my 'reading' of the data (J. Cromby, personal communication, July 4, 2007). Although such an analysis would exceed the scope of my research I recognise that it could offer a new and valuable perspective on the repertoires investigated.

5.2.2 Problems, qualifications and future research

This research deals with individual constructions in talk and therefore the representatives of my findings requires further thought. Discourse analysts by and large oppose homogenising notions of discourse and reconceptualise disciplines as a contested field of competing discourses (Foucault, 1991). If 'psychology' is thus rethought as always heterogeneous, all views expressed by informants are part of this discourse and are therefore of undeniable significance. In other words, it would be impossible to take any one set of views as representative of 'clinical psychology'. In methodological/epistemological terms this means that a discursive notion of 'psychology'

enables us to regard discourse data as snapshots of discourses that are part, but never fully representative, of the particular field under investigation.

Nevertheless, this does not mean that the study of discourse can only remain at the individual level. For example, in a study of scientists' discourse, Gilbert and Mulkay (1984) analysed the divergent accounts of 'science' in experimental papers, interviews and conference presentations, to demonstrate how accounts are generated and inconsistencies managed at a disciplinary level. I would argue that this would be a worthwhile extension of my research, in which the wider context has not been of direct concern. Here, it must be acknowledged that there are alternative views of discourse that remain concerned with language use and are not restricted to the realm of small-scale talk (e.g. Fairclough, 1992, 1995; Fairclough & Wodak, 1997; Titscher, Meyer, Wodak, & Vetter, 2000; Wodak, 1996b). Extending the analysis to include types of data similar to those used in Gilbert and Mulkay's study (1984) could help identify the disciplinary interpretative repertoires used to construe cultural competence. This would be useful because the disciplinary context of psychology was a recurrent feature in my informants' repertoires. If we could identify, describe and document the recurrent repertoires on cultural competence that are constructed out of the wider diversity of disciplinary positions it could lead to a rethinking of our conceptual underpinnings and to adjust the nature of our frameworks for cultural competence. In terms of evidence presented here, due to the inevitably limited scope of my study, we may therefore have to be content with producing evidence that reflects a small part of such a wider study.

Table 1: Interview Sample

Post Qualification Experience	
Up to 1 year	1
1 year to 5 years	1
6 years to 10 years	1
11 years to 15 years	1
16 years to 20 years	2
Clinical Area	
Adult Mental Health	2
Child Adolescent Services	2
Learning Disabilities	1
Refugees/Asylum Seekers	1
Geographic location	
North-West	2
North	1
Midlands	3
Ethnic Group	
White British	5
Black African	1
Gender	
Female	5
Male	1

Table 2: Group Discussion Sample

Post Qualification Experience	
Trainee	1
Up to 1 year	1
2 year to 5 years	1
6 years to 10 years	1
Over 14 years	1
Clinical Area	
Adult Mental Health	5
Geographic location	
Midlands	5
Ethnic Group	
White British	5
Gender	
Female	2
Male	3

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Critical Reflection

1 Introduction

My prime concern here is the dynamic which has led to the contents of this thesis, a review of literature on the subject of race equality in mental health care and an empirical study on psychologists' discourse on working with minorities. What follows is a retrospective sketch of the process of decision-making that has led to the present thesis. This reflection is drawn from my field-work and reflective journal, as well as other research record keeping, such as supervision notes, analytic memos and summaries from a 'qualitative support group' that I attended throughout the course of this research. To examine my thesis in full is to attempt to discover what my research omits as much as, if not more than, what it includes. That is the first step in my critical reflection. The second step is, of a biographical or personal nature, to trace and present what has constituted my role and influence on what has been produced, as well as how carrying out this research has impacted upon myself. This will be largely reflected upon from my status as a minority ethnic trainee clinical psychologist conducting research on clinical psychological approaches to working with minorities.

A secondary concern in this part is to highlight what criteria for evaluation I employed in this research. My guidelines for good practice are drawn from general principles for good practice in qualitative research while acknowledging idiosyncrasy and method-sensitivity for evaluating discourse analysis (Madill, Jordan & Shirley, 2000; Reicher, 2000; Willig, 2001). Certain general points can be made about qualitative research. The research

should demonstrate appropriateness of methods, clarity of presentation and attention to reflexivity issues (Altheide & Johnson, 1998; Elliott, Fischer and Rennie, 1999; Fitzpatrick & Boulton, 1994; Flick, 2006; Hammersley, 1992; Henwood & Pigeon, 1992; Huberman & Miles, 1998; Lincoln & Guba, 1985; Silverman, 2001; Wolcott, 1990). It is hoped that the trustworthiness and rigor of my study is enhanced by the process of clearly explaining and describing each stage of the research (the reader may want to look back to Part 2 in this thesis to see what stages the researcher described). In addition, in my study I have displayed sufficient data to show how the results are grounded in the data (Henwood & Pigeon, 1992; Taylor, 2001), I met with another discourse analyst who was not involved in the research in order to discuss the analytical procedures and check alternative plausible interpretations (Elliott, Fischer and Rennie, 2000), and I evaluated the validity and reliability and hence limitations of my research within the method specific terms of discourse analysis (see Part 2 section 2.5, pp.88-89). What remains to be done here is, to draw on the field notes made throughout the duration of this study to reflect on the way my presence has contributed to the analysis, making personal and theoretical biases explicit and evaluating the impact of my epistemological position, in order to demonstrate my awareness of what a study based on discursive psychology is able to deliver (Willig, 2001).

1.1 Discourse Analysis: Epistemological Issues

Some of the criticisms of discourse research are that it is ‘textual deconstruction’ ‘researching down’ to the micro contexts of talk, and that it is an exercise by the academy that does not consider the production of dominant power relations and thus reproduces

them (J. Cromby, personal communication, July 4, 2007). It is in response to such criticisms that numerous ‘critical’ approaches to discourse have been articulated, which keep an analytical eye on the micro context of talk whilst extending the focus to the wider context within which the talk occurs (Fairclough, 2003). Moreover, many critical approaches argue that without a consideration of the wider context the analysis of ‘talk’ by itself can only tell us ‘how’ people talk about a particular subject and not, crucially, the actual consequences of certain ways of talking about a particular phenomena (Fairclough & Wodak, 1997; Sherzer, 1987; van Dijk, 1997a; 1997b). That is, some discourse approaches, in particular Potter and Wetherell’s (1987) approach adopted in this study, can tell us ‘how’ constructions are made in talk, but not whether these constructions have actual ‘real’ effects. A particularly illuminating empirical study on the effects of constructions is Verkuyten’s (2005) study of strategies used by Dutch majority ethnic group members to define categories of immigrants in Holland, and the implications of these definitions for the evaluation of cultural diversity. In this study Verkuyten (2005) adopted a ‘critical’ social constructionist position.

In my research I adopted a social constructionist position, which was concerned with ‘versions’ of events and the discursive strategies used to work up these versions. It remains at the level of discursive consequences, because it begins with an examination of those discourses and devices that appear naturally in the course of the participants’ own discourse and it extends the analysis to cope with ‘structural phenomena’ only to the extent that it is possible to provide detailed analysis for the analytical claims being advanced (Gilbert & Mulkay, 1984). Another key reason for remaining at the level of the

talk itself is the move away from a focus on the cognitive dimensions. Potter and Wetherell (1998) summarise this by underlining that ‘discourse analysts have not been against the study of cognitive phenomena, but they have been interested in them as features of people’s activities’ (p.140). For the purposes of this thesis, this means that in the process of analysing psychologists’ discourse, the analytical focus was not on the cognitive representation of ideas but on the level of their discursive communication and negotiation. I chose to deal with what was for me, and is still in writing this reflection, an interest in the construction and versions of discourse, the variability of arguments underlining the idea of cultural competence. This does not mean that I have not been concerned about the ‘social context’ and the wider implications of certain constructions; it has actually been a major concern in my thinking. If I did not think that construction processes had implications, I doubt that I would have been able to undertake a discourse analysis for the purposes of meeting my research aims.

My use of a social constructionist view of discourse analysis stays close to the position of Gilbert and Mulkay (1984) and emphasises that ‘social context’ does not exist independently of participants’ discourse. For social contexts are themselves ‘products’ of discourse. This is a Foucauldian position, which is not conventionally found in discursive psychological studies, such as mine. However, this is not to say that discursive psychologists as well as other discourse analysts do not attempt to marry a Foucauldian perspective with a primary focus on the talk itself (see Edley, 2001; Parker, 1992; Willig, 2001). Such approaches played a key role in the very early stages of my research, and whilst they do not feature very much, if at all, in the other parts of this thesis, they are of

substantial significance to how the theoretical review and empirical work in this thesis were thought about and constructed. Therefore, in this more retrospective part of the thesis, I will outline how I developed my understanding of discourse analysis and how this led to the epistemological and methodological position currently adopted in my research.

1.1.1 Foucault and my epistemological thinking

Grossly simplifying his work³⁸, Foucault is concerned with attempting to contextualise and historicise the notions of truth, knowledge, rationality and reason that are found within society at different times and to show how these relate to the construction of individual identities (Danaher, Schirato & Webb, 2000). In his historical investigations into the origins of the powerful institutions and discourses that are found within societies, Foucault (1972; 1973, 1977, 1980) used documentary evidence to try and make sense of the relationship between the individual and the context in which they find themselves. The thread running through all of these studies is how different discourses, taken from criminology, psychology and theories of mental illness and sexuality, were applied to deviants, the mad, the criminal and those whom we would now call sexual deviants, to sort out, categorise and define different types of person who in one sense did not exist before, that is they create subject positions (Benton & Craib, 2001)³⁹. This leads Foucault to see the individual as being, to some degree, regulated and controlled by the

³⁸I will outline, very briefly, what I take to be the most important characteristics of Foucault's work with regard to the present thesis. More informative accounts can be found in the following: Maingueneau & Angermüller, 2007; Mills, 1997, 2003; Parker, 1995.

³⁹ For instance, in his work *The birth of the clinic* (1973), Foucault argues that 'early psychiatry helped to constitute the object "madness" which it then developed to treat' (Donnelly, 1986, p.18). As some feminist theorists have argued, the 'mental health services...have helped to maintain the social status quo by naming and managing as "madness" the psychological damage and distress caused by social inequalities' (Williams, Scott & Waterhouse, 2001, p.98).

structure and discourses within which they exist (Baker & Galasiński, 2001). Although such relations between the individual and society may demonstrate the coercive and repressive relations of power (McNay, 1994), Foucault is more concerned to explore the ways in which power works as a positive and enabling force through the creation of particular identities and subjectivities⁴⁰ (Foucault, 1988). In other words, the reduction of all discourses to oppressive power relations can paint a decidedly one-dimensional picture.

Something that particularly interests me in Foucault's ideas is the dialectical nature of discourse, and how people may grapple with and attempt to make sense of or reconcile the discourses that they construct themselves and those that they are subjected to. I thought about this in relation to both mental health service users and mental health professionals. For example, how a minority ethnic service user negotiates their position and their cultural beliefs in mental health services and how mental health professionals approach work with minority ethnic clients. These ideas seemed particularly pertinent in light of the, at that time, new Department of Health policy 'Delivering race equality in mental health care' [DRE] (DoH, 2005), and the report of the inquiry into the death of David Bennett, an Afro-Caribbean service user who died in a secure psychiatric unit after being restrained by staff. In this context, and the wider context of the changes in the Race Relations Amendment Act (2000), the Equality Act (2006) and the new Commission for Equality and Human Rights (2006), there is a call on mental health services and thus professionals to account for their efforts to make services culturally appropriate for minorities. I was keen to explore a number of minority ethnic and

⁴⁰ A subjectivity is produced in discourse as the self is subjected to discourse.

professional issues within this increasing focus on cultural competence. These included: a consideration of whether the overrepresentation of Afro-Caribbean people in acute mental health services could be understood as a failure to appreciate their difference and thus may also be related to wider mental health and professional discourses; a consideration of how the policy DRE aims to engage minorities in this effort to create more appropriate services; and finally, an attempt to understand how mental health professionals, in this case specifically psychologists, thought about and interpreted cultural competence. The former two have informed the main study in my research and I will now describe that process.

1.1.2 Preliminary studies

I applied a Foucauldian discourse analysis (Willig, 2001) to the policy DRE and to some data on Afro-Caribbean experiences and outcomes from mental health services. A Foucauldian discourse analysis is concerned with identifying the way in which things are constructed and how these constructions or discourses ‘both allow and limit the possibilities of understanding the object or event’ (Langdrige, 2004, p.337). For example, we may focus on the way a particular identity or ‘subject’ such as ‘refugee’ is constructed. In my analysis of the DRE, I focused on the idea of ‘community engagement’ espoused by the policy, and revealed that minority ethnic women, as well as other groups of minorities (some religious groups), were particularly vulnerable to not being included in the policy’s community engagement plans or protections, because of their limited recognition within the policy. The results of my analysis are presented in Appendix L, and takes the form of a poster, which I presented at the ‘Delivering Race

Equality: Research, Policy and Practice' conference, held by the National Institute for Mental Health in England in 2006. This analysis led to the development of my literature review, presented in the first part of this thesis, as I was inspired to further engage with the complexities of language in policy.

The Foucauldian analysis of some empirical findings (identified from my literature review) on some of the inequalities experienced by minority ethnic service users, particularly Afro-Caribbean service users, was carried out to develop my epistemological position. Specifically, I was interested in gaining some 'hands on' experience in researching language use and how particular constructions are made. The results of my analysis are presented in Appendix M.

The exploration was fruitful in terms of familiarising myself with discourse analysis. Although I had only made a 'theoretical' exploration, of definitions and category constructions having an effect on the overrepresentation of Afro-Caribbean people in mental health services, I was particularly struck by the usefulness of the contextual approach in thinking about wider systems and settings. I also felt that a social constructionist focus on what is going on in the text or talk is potentially very far removed from actual contexts (Nightingale & Cromby, 1999). Therefore, I re-searched the discourse literature for studies within the 'critical' discourse approach, to see how they managed to incorporate a wider contextual focus, whilst retaining a focus on the actual talk. I identified a number of discourse approaches that focused on talk and context, which employed wider materials, such as policies, disciplinary literature,

political speeches and newspapers (e.g. Fairclough, 1989, 1992, 1995, 1996a, 1996b; Fairclough & Wodak, 1997; Kendall & Wickham, 1999; Mayr, 2004; Parker, 1992; van Dijk, 1984; Widdowson, 2004; Wodak, 1989; 1996a). The particular analysis that I had in mind was a focus on documents published by the British Psychological Society (BPS), such as the code of ethics and practice, to complement my analysis on psychologists' discourse.

My prime aim was to keep a focus on individual psychologists' discourse and try to compare and contrast this with the wider disciplinary discourse, to gain a wider interpretative picture of the repertoires deployed in individual talk. However, the analysis was particularly problematic due to the risk of falling into a one-dimensional analysis of power, which seems to be the tendency in this type of approach.

1.1.3 Difficulties in conducting a wider contextual analysis

Generally with discourse analysis approaches I have struggled with the stance that a guide to conducting the analysis is not possible (Phillips & Hardy, 2002; Potter & Wetherell, 1987; Seale, 1998), because it is a matter of developing tacit expertise (Wooffitt, 2005) and a certain analytic mentality developed from a lot of careful and reflective reading (Schenkein, 1978).

In addition to the general vagueness, the analytical concepts employed by the more critical and contextually oriented approaches draw heavily on sociological terms, such as

hegemony, which were not always easy to grasp⁴¹. Approaches in this field draw on Foucault's ideas and attempt to link individual talk to wider social processes, to show how individual constructions may strive to become hegemonic or taken for granted through a process of naturalisation (Billig, 2001a 2001b; Durrheim & Dixon, 2000; Gill & Whedbee, 1997; van Dijk, 1996; 1998). They adopt an explicitly critical stance from the outset of the research (van Dijk, 1993). However, I found that such approaches are often a one-dimensional application of Foucault's ideas that do not engage with Foucault's view of enabling power (Fairclough, 1992; Macdonell, 1986; Merquior, 1985). Moreover, the aim of my study was not to recover ideological beliefs from participants' talk, but to look at how accounts of cultural competence are being constructed, and to find a way of contextualising this. I felt that in adopting the 'critical' approaches to discourse I would run the risk of being overly deterministic, which would make it hard to approach my data without a definitive (negative) agenda. I was acutely aware of this from my preliminary Foucauldian analysis of ethnicity and inequalities (Appendix L & M), which is equally guilty of similar shortcomings: I have not paid attention to the ability of minority groups to resist discourse, the emotional investments minorities make in ethnic groups and their attachment to their group. This has alerted me to the problems of trying to conceptualise talk within context. In particular, there is the risk of explaining the constructions of cultural competence by clinical psychologists as the outcome of the dominant discourses. The use of disciplinary documents could be seen to have potential overtones of seeking confirmatory evidence to support this claim.

⁴¹ van Dijk (1993) makes a similar point that text books on discourse analysis are rarely informally/accessibly written.

Whilst a wider contextual focus in my analysis could have offered a fuller exposition of what the identified interpretative repertoires mean, in relation to the disciplinary discourse, I decided to abandon the attempt to do so, because of the difficulties encountered. I acknowledge that there are more complex ways of answering my research question, but at the time of initiating the research I had considerably less knowledge and experience of discourse analysis and therefore I was not able to find a method to undertake that level of analysis. Even though I probably had not exhausted the range of contextual approaches available, in order to avoid further confusion and ‘dead ends’ I decided to remain at the level of the individual talk. The point that I wish to make is that data analysis does not constitute a stand alone section of the research process. Instead, throughout the various stages of this project an element of analysis, albeit to varying degrees, has been at work, from shaping the underlying theoretical approach to the research methods employed and data collected. By engaging with such ‘critically’ different approaches, I came to appreciate the value of the approach that I had initially set out with, for the perhaps simple, but crucial, principle that it allows the analyst to stay close to the data. Although the consequences that I can detail in my analysis are talk based, this is nevertheless important as it constitutes a necessary prerequisite for further ‘actual’ consequences. Furthermore, I feel motivated to re-attempt a broader disciplinary analysis, in the future, as a way of extending the present study.

1.2 Myself as the Researcher

The discussion thus far has focused on reflexivity in terms of my epistemological position and its implications for my methodology. What remains to be discussed here is

reflexivity concerned with my personal interactions with the research and interpretations of the research data. These two sections comprise the concluding parts of this thesis.

1.2.1 Cultural competence as a personal issue

As a minority ethnic clinician/researcher and doing research on psychological provisions for minority ethnic groups called for further self-reflection. For instance, I felt a pressure or expectation, generated from myself as well as from my reading of other research in the area of ethnic and cultural diversity, to use my relatively privileged position to ‘challenge’ (Riggs & Choi, 2006; van Dijk, 1993; 1997a; 1997b). Researchers argue that studies in which theory “floats disconnected from any political position” raises problems of relativism (Burman & Parker, 1993, p.167), making it difficult to evaluate situations and consider ways in which they might be changed. A look at the positions adopted by other discourse researchers in my area shows that it is often an overly critical position that is taken, as discussed previously. Such a definitive position felt highly unsatisfactory to me, and at other times I felt that a more questioning approach would be helpful in exploring cultural competence and how to proceed, at the very least in terms of my own thinking, with clinical change. For instance, during one of my clinical placements in an acute ward setting, I observed what seemed to be mostly reserved interaction between Afro-Caribbean clients and the staff, who were of White British background and the more two-way relaxed exchange when ethnicities were shared. This is, of course, just one snapshot of a partial picture; the point is not to recollect memories and events that have had a significant impact on my thinking in this research area, although that would be wholly appropriate to a qualitative project (Hammersley & Atkinson, 1995), rather it is to

highlight the continuities between my research reflection and my personal reflection (Alvesson & Sköldberg, 2000; Chouliaraki & Faiclough, 1999). That is, being a 'minority' has been largely my experience and thus in my awareness, so that researching about minorities is undoubtedly also emotive for me. Research is often generated by self-interest, as noted by Foucault:

Whenever I have tried to carry out a piece of theoretical work, it has been on the basis of my own experience, always in relation to processes I saw taking place around me. It is because I thought I could recognise in the things I saw, in the institutions with which I dealt, in my relations with others, cracks, silent shocks, malfunctioning...that I undertook a particular piece of work, a few fragments of autobiography (Foucault, cited in Eribon, 1991, pp.28-29).

Interestingly, even though Foucault concludes that his work may be about a particular aspect of his 'biography', I find myself hasten to call an alert to biases. This is not to presuppose an 'objective' or 'neutral' position, but rather to suggest that whilst our research thinking can be intimately connected to our personal thinking and experiences, in my view it is not in the spirit of good research to let our personal views triumph over the views of our participants (Flick, 2006; Hammersley, 1992). I think that our views should be considered, reflected upon and made clear (Alvesson & Sköldberg, 2000; Clegg & Hardy, 1996; Holland, 1999; Silverman, 2001), but I do not think that we need to get into a dualism between our thoughts and what is happening in the research. I found it helpful to keep a reflective (separate to my fieldwork) journal in which I could log my

theoretical reading and my reflections on the reading. Not only did this provide a useful way of tracing the development of my views over the course of this research, it also helped to ground and make explicit the way in which I was orienting to other studies and views in my area of research. Going beyond such largely self-observatory remarks, parts of the following discussion will suggest that whilst reflecting on one's own position is common in discourse analysis, the aim is not to compromise our interpretation of the participants' discourse.

1.2.2 Making sense of the analysis

Reflexivity also includes thinking about how we have approached and examined our data in light of the views and positions that we have acknowledged (Atkinson & Coffey, 1997; Willig, 2001). In line with the discourse theme of this research, my 'contribution' to the construction of meaning presented in the present research must be freely acknowledged (Gill & Whedbee, 1997; Nightingale & Cromby, 1999; Phillips & Hardy, 2002).

Although it is impossible to approach data without certain 'hypotheses' and conceptual frameworks (Lehtonen, 2000), I attempted to approach my data as neither too committed to my own ideas or as clearly outside of my participants' ideas, in order to be flexible rather than restrictive in the analysis of data (Miller & Glassner, 1997). By continuously asking: why am I reading this account in this way? What invokes this reading? (Potter & Wetherell, 1987, p.168), I was able to maintain an awareness of the perspective that I was taking on a particular account. Nonetheless, this did not mean that I found making interpretations any easier. It certainly was a complex task trying to make sense of another person's talk. It partly was a matter of judgement and evaluation; for example,

judging which discursive device is being employed and to what purpose. This final caveat acknowledges that the researcher's perspective is part of the construction processes under investigation, and perhaps what is more important than the particular 'position' she takes, is whether her position is acknowledged and spelled out for the reader. It is hoped that the reader will take the discussion on the epistemological and personal background that I invoke in my research, as a reflection on my contribution to the constructions in the present research (Blommaert, 1997; Galasiński, 1997; Jørgensen, 2003; Verschueren, 1999)

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1.2.3 Concluding thoughts

As a final reflection, whether this research functions to challenge or whether it is more bounded and static, depends on how people view it and whether it can be extended beyond the realms of academia in which it is constituted. It is hoped that this research has demonstrated some current perspectives on race equality and cultural competence which has relevance to the practice of psychology and particular relevance in the training of psychologists. The fact that my study highlights that it is a difficult and complex task to construct an integrated model of cultural competence, should encourage us not to be so quick to formalise and fix our ideas on the subject. Instead, it is the conviction of this project to keep that line of thinking open and not to ignore the oscillation between generalist and specialist frameworks. I strongly believe that clinical and training efforts in the area of cultural competence must avoid a 'totalising' model, whether that is culturally or therapeutically driven, and, instead, engage in more discussions among psychologists but also between psychologists and minority community members, because

it is difficult to evaluate a model on its own 'psychological' terms. In clinical and empirical terms, there is undoubtedly much more talk to be done on clinical psychologists' decoding and construction of cultural competence. Like all discourse, this discourse is by no means complete. The present study constitutes, at best, another discourse in this ongoing analytical journey.

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Appendix A

Manuscript Requirements for Publishing in the British Journal of Clinical Psychology⁴²	Criteria met or not applicable
The following types of papers are invited: 1. Papers reporting original empirical investigations; 2. Theoretical papers, provided that these are sufficiently related to empirical data	Empirical paper Literature Review
Papers should normally be no more than 5000 words	N/A
Contributions must be typed in double spacing with wide margins. All sheets must be numbered.	Criteria met
Tables should be typed in double spacing, with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text. Figures should also be placed at the end of the manuscript.	Criteria met
For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: objectives, design, methods, results, conclusions. Review articles should use these headings: purpose, methods, results, conclusions.	Criteria met
For reference citations, please use APA style.	Criteria met

⁴² Retrieved from the British Psychological Society Website:
<http://www.bps.org.uk/publications/journals/bjcp/notes-for-contributors.cfm> (May 2, 2007)

Appendix B

1/05/2006 Version 2



School of Psychology

Clinical Section

104 Regent Road

Leicester LE1 7LT · UK

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**Participant Information Sheet: For
Interviews**

CLINICAL PSYCHOLOGICAL APPROACHES TO WORKING WITH MINORITY ETHNIC GROUPS

DClinPsy Research Project

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

1. Reasons for the Research

My aim in conducting this research is to explore how clinical psychologists work with minority ethnic clients and how they feel about it. Your views are important as clinical psychology services are under accessed by minority ethnic groups. I feel that a more complete understanding of clinical psychologists' views and approaches to minority ethnic mental health will be very useful and may have an impact on future clinical psychology provision. This research is part of my doctorate in clinical psychology.

2. What Participation Will Involve

I am keen to talk to clinical psychologists from all backgrounds and with all experiences of work with minority ethnic groups. The only thing I would ask is that you are currently working with minorities. This is because I am particularly interested in talking to you about your current experiences. Taking part in the research is entirely voluntary. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

If you decide that you would like to be involved in my research then this would entail an interview with me that will last approximately 1 hour.

The interview will cover issues such as your understandings of mental health in minority ethnic groups, your experiences of working with minority ethnic groups and your thoughts about clinical psychological work with minority ethnic groups in general.

Everything that you say in the interview will remain strictly confidential and will not be shared with anyone else. I am obliged to report to my supervisor if any information came to light, which suggested poor practice, or a breach of clinical governance.

3. How to Get Involved

If you are interested in taking part in my research then I would be delighted to hear from you. My contact details are printed at the bottom of this information sheet. When you contact me I will provide you with more information and will be happy to answer any questions.

FOR FURTHER DETAILS PLEASE CONTACT

SAIMA MASUD

School of Psychology, Clinical Section, University of Leicester

104 Regent Road, Leicester, LE1 7LT

E-mail:

Telephone:

Appendix C

01/05/2006 Version 2



**School of Psychology
Clinical Section**

104 Regent Road
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Interview Schedule

Introduction

- I'd like to start by thanking you for your time and for agreeing to be interviewed, it's very much appreciated
- I'd also like to assure you once again that anything you say will be treated in the strictest confidence and that any material used in the writing up of the research will be anonymous
- Is it okay to tape? Your name will not be attached to anything. (If uncertain can offer to send transcript for checking).
- The interview will probably last about an hour and I'll be asking you some specific questions, but do please feel free to suggest something that you would like to talk about if you think there is an issue I've overlooked or that you feel is particularly important to you and we haven't covered so far.
- Do you have any questions before we start?

History of work with minorities

- I'd like to start by asking you to tell me a little bit about your experience of working with minorities
- It's probably easiest if you start in the present, telling me about your current experience, and work backwards
- Pick up on any immediately interesting things, such as work with hard to reach minorities, strong views/opinions or particular experiences
- Ask them if they can say a bit more about that and try to draw out reasons

Understandings of minority mental health

- If we could move on to talk about minority mental health itself and maybe I could ask you to tell me how you see and approach it
- Pick up on any immediately relevant/interesting aspects of their response
- If they have mentioned differences from a Western perspective then ask what they think about the Western and Non-Western perspective, both in the specific case and more generally

Information about minority mental health

- Can I ask where and/or who you get your information about minority mental health from?
- If they mention community/voluntary services then ask them what they think about the information from these sources
- Do you get information from any other people or places?

- Pick up on any immediately interesting things such as from clinical training course, other training courses, or colleagues
- Do these different forms of information ever contradict each other?
- Do you consider any source of information as more reliable than others?
- If so, which and why?
- Does the information that you have received match your understanding of mental health?

Importance of minority mental health

- Do you feel that working with minorities is important to you?
- Explore any answer given
- Is working with minorities equally important for all clinicians? What I mean by that is do you think that all clinical psychology training courses definitely should teach about working with minorities, or whether it isn't so important for all areas of clinical practice?
- If so, which areas and why?
- Can you tell me why you think that?
- Does your clinical training have an effect on how you think about mental health in minority communities and how you work with them?
- Ask them if they can say a bit more about this

Effectiveness of clinical psychology

- I'd like to know whether you think clinical psychology is effective in working with minorities?
- Can I ask you to say a bit more about that and tell me why you think that?
- Try to draw out models and frameworks used and implications for formulation
- Have you ever heard or experienced anything that might have changed your mind?

Anything else

- We've now covered all the areas that I specifically wanted to talk about, is there anything else that you would like to cover?
- Please feel free to suggest something as it's unlikely that I've thought of everything!

End

- I'd like to thank you once again for your time and for an interesting discussion
- You've been very helpful and if you have any questions or concerns after I've left then do please contact me

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Clinical Section

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Consent form

CLINICAL PSYCHOLOGICAL APPROACHES TO WORKING WITH MINORITY
ETHNIC GROUPS

Researcher: Saima Masud

Please initial box

1. I confirm that I have read and understand the information sheet dated
(version) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason.

☐
3. I agree to take part in the above study.

☐
4. I agree to the interview being audio recorded

☐
5. I agree to the use of anonymised quotes in publications

☐

Name of Participant

Date

Signature

Researcher

Date

Signature

Appendix E

1/05/2006 Version 2



**School of Psychology
Clinical Section**

**Participant Information Sheet:
For Group discussion**

104 Regent Road
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CLINICAL PSYCHOLOGICAL APPROACHES TO WORKING WITH MINORITY ETHNIC GROUPS

DClinPsy Research Project

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what participation will involve.
- Part 2 gives you more detailed information about the conduct of the study.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1. The Purpose of the Research

My aim in conducting this research is to explore how clinical psychologists work with minority ethnic clients and how they view it. Your views are important as clinical psychology services are under accessed by minority ethnic groups. I feel that a more complete understanding of clinical psychologists' views and approaches to minority

ethnic mental health will be very useful and may have an impact on future clinical psychology provision. This research is part of my doctorate in clinical psychology.

2. What Participation Will Involve

I am keen to collect 'natural' relaxed conversational interactions between clinical psychologists on the particular area of culture and clinical psychology. This is because I am particularly interested in clinicians talking amongst each other in their own relaxed language with no interference from the researcher. I would like to collect a tape recording of your group discussion. I will not be present at the discussion, but would ask a group to press the record button for me! This is because I want the discussion that I record to be as 'natural' as possible. Taking part in the research is entirely voluntary. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason, the discussion can go ahead as planned and the tape recorder can be switched off. If you are happy for me to tape record the discussion, I can send you a copy of the transcript of the tape-recording collected from the discussion before I begin using it for analysis so that you can then veto the use of the tape if you wish to do so.

3. Potential Risks and Benefits of Taking Part in the Research.

I can not promise the research will help you but the information that I get might help inform clinical psychology theory and practice in the area of working with minority groups, which could have a positive impact on minority groups.

My research will not require names and details of individual clients, but case details discussed in the group may be distinctive and recognisable. The discussion may involve issues of poor practice. Where this is a possibility, I will be careful not to present large chunks of data at once, and I would discuss with the group, as well as my supervisor, any concerns that I may have.

If you decide that you would like to be involved in my research then this would entail allowing me to audio-tape record your discussion. The tape will be transcribed in full

and coded, so that group members will be identified by a pseudonym and the list linking these to the group members' real names will be kept locked in a separate cabinet. The tape will be destroyed after transcription.

Everything that you say in the meeting will remain strictly confidential and will not be shared with anyone else.

3. How to Get Involved

If you are interested in taking part in my research then I would be delighted to hear from you. My contact details are printed at the bottom of this information sheet. When you contact me I will provide you with more information and will be happy to answer any questions.

FOR FURTHER DETAILS PLEASE CONTACT

SAIMA MASUD

School of Psychology, Clinical Section, University of Leicester

104 Regent Road, Leicester, LE1 7LT

E-mail:

Telephone:



School of Psychology
Clinical Section

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Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

Consent form

CLINICAL PSYCHOLOGICAL APPROACHES TO WORKING WITH MINORITY
ETHNIC GROUPS

Researcher: Saima Masud

Please initial box

- 1. I confirm that I have read and understand the information sheet dated
(version) for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily. ☐
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason. ☐
- 3. I agree to take part in the above study. ☐
- 4. I agree to the discussion / meeting being audio recorded ☐
- 5. I agree to the use of anonymised quotes in publications ☐

Name of Participant

Date

Signature

Researcher

Date

Signature

Appendix G: Steps taken in discourse analysis⁴³

Step 1: Read through the transcript a few times.

Step 2: Note what leaps out as I read through the excerpt.

What is the participant 'doing' with the talk?

What *conversational device* is involved? (e.g. blaming, justifying, accounting, excusing, and describing).

[REDACTED]

Is the narrative structure of this account important?

Are there any 'repertoires' operating in the text?

What sorts of descriptions do participants attribute to themselves and to others?

How are the issues of blame and accountability organised throughout the interview?

Step 3: Note down what seems most interesting so far, in each transcript.

Repeat.

Step 4: Make detail notes on identified areas of interest.

Make links with the discursive devices/strategies employed – to show what the participant is 'doing' with the talk.

⁴³ These steps are drawn from: Gilbert & Mulkay, 1984; Hoton-Salway, 2001; Potter & Wetherell, 1987.

Step 5: Match devices to the relevant articles.

Step 6: Write up findings. Select a number of extracts, if possible group into the key discourses/repertoires.

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
DERBY
DE1 1LJ

Appendix H

Telephone: 01332 868842
Facsimile: 01332 868785

12 September 2006

Miss Saima Masud
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust, & the University of Leicester
University of Leicester
Department of Psychology, Clinical Section, 104 Regent Road
Leicester
LE1 7LT

Dear Miss Masud

Full title of study: Clinical Psychological Approaches to Working with
Minority Ethnic Groups
REC reference number: 06/Q2502/54

Thank you for your letter of 09 August 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application	Version 1	24 May 2006
Investigator CV	Version 2	01 May 2006

Protocol	Version 2	01 May 2006
Covering Letter	Version 1	01 May 2006
Peer Review	Version 2.0	16 May 2006
Interview Schedules/Topic Guides	Version 2	01 May 2006
Letter of invitation to participant	Version 2	01 May 2006
Participant Information Sheet: Interviews	Version 3	09 August 2006
Participant Information Sheet: Special Interest Group	Version 3	09 August 2006
Participant Consent Form: Special Interest Group	Version 2	01 May 2006
Participant Consent Form: Interviews	Version 2	01 May 2006
Response to Request for Further Information	Version 1	09 August 2006
REC original letter of unfavourable opinion	Version 1	01 February 2006
Supervisor CV	Version 2	01 May 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2502/54	Please quote this number on all correspondence
--------------------	---

With the Committee's best wishes for the success of this project

Yours sincerely


Chair

Email: sarah.gill@derwentsharedservices.nhs.uk

Enclosures: *Standard approval conditions (SL-AC2)*

Copy to: Dr David Clarke
Leicester Partnership NHS Trust
George Hine House
Gypsy Lane
Leicester

Appendix 1

Dear Saima

Your project (clinical psychology discourse on difference) has been approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be printed out and kept for your records or attached to the research report if required – this includes all undergraduate and postgraduate research.

We wish you every success with your study.

Andrew M. Colman
Psychology Research Ethics Committee Chair

-----Original Message-----

From: www-data [mailto:webserver-admin@leicester.ac.uk]
Sent: 28 March 2007 12:53
To: amc@leicester.ac.uk
Subject: PC_ethics2006 – saima masud

Proposer: PC_ethics2006 – saima masud
email: sm295@le.ac.uk
status: 3rd year postgrad student
supervisor: Prof. Mike Wang
title: clinical psychology discourse on difference
date: 28/03/2007
preapproval: LMRC
describe:
tellvoluntary:
obtainwrittenconsent:
observe:
withdraw:
allowomit:
tellconfidential:
debrief:

mislead:
distress:
animals:
kids:
sen:
patients:
custody:
criminals:

route:

routeAdesc:

routeBdesc:
RouteBsupp:

Appendix J

Derek and Tim's excerpt from the group discussion

163. I can chart an example from yesterday
164.seeing a client whose mixed race and I had an awareness from the referral that
165.she'd had a rough time at school so we were talking about this and still tease
166.various things apart, because it's complex and she's not an amazingly open
167.person anyway, but we were just chatting about, I've only seen her a few times,
168.and we were chatting about her kind of school experience and she was saying
169.that oh she was teased because of her mixed race and I kind of, maybe with
170.hindsight maybe, not kind of blundered in a bit er and said, oh what were some of
171.the names that people called you then, and her response to that was 'I don't want
172.to talk about it, because it's too horrible', and I kind of felt well you know
173.looking at it now, thinking through a race and culture perspective, was that
174.because I was just a bit you know, we come from absolutely vastly different
175.arenas of life, was that because (inaudible) in lots of different areas, or was that
176.could I have handled that a bit more sensitively or what ever, but it felt very
177.much as you know 'fuck off don't ask me about that' and then it kind of is a right
178.and sensitive topic and it's not the only one and that you know we were talking
179.the other day about how much you ask women about kind of abusive sexual
180.experiences and how much does it start to become uncomfortable, with your
181.position versus theirs and when you know how do you do that in a meaningful

182.way and so maybe in a similar maybe there's some similarities there, but it felt as
183.though I was just kind of pretty clumsy erm, but that might not have been it
might
184.have been that I was challenging open and honest and asking coz I thought it you
185.know it's useful for me to know the extent of this you know does it link with the
186.voices that she might be hearing or what ever erm, but it kind of all felt a bit
187.difficult and uncomfortable.

188.Tim: Yeah, at the same time, because you partly mentioned a little bit
189.about that client about the whole process of certain things she's likely to say 'I
190.don't want to talk about' and that wasn't necessarily about to do with her
191.ethnicity and so on either was it, so then I'm wondering how much that's a
192.response you know over a number of things for that person, because so I suppose
193.what I'm partly saying is that it didn't sound that clumsy when you said it
194.actually when you were thinking maybe ooh maybe was it, I'm not sure if it was
195.and it made me think about somebody I saw is from mixed race, a guy a few
196.years ago now, and I think I asked something quite similar at a similar sort of
197.stage again being around bullied and so on, maybe called names and I can't
198.remember the details immediately, but it was to do with his race and ethnic sort
199.of background and I learnt quite a lot, because I'd sort of asked a similar thing at
200.a similar time and everything and it was really I felt it seemed appropriate, and
201.the client seemed comfortabish with it and actually I learnt quite a lot because
202.what I learnt such thing I remember was that this guy felt that he just didn't fit
203.into Africa-Caribbean he wasn't black enough and he wasn't white enough and it

204.really made me think it was the way he said it just seemed really powerful that he

205.that's exactly how he [described it

206.QPM1: [he was a bit more open about it]

207.QPM3: [yeah] and equally then did leave quite a lot of room open for

208.discussion. But I can't imagine that I was anymore sensitive or you know

209.thoughtful than you, in the way you asked it, so I think we have to be careful

210.about not

Appendix K: A Summary of Cultural Competence Models / Guidelines

1. Study: Barrett (2005): Guidelines for conducting cross-cultural evaluations in psychology (for the courts). (USA)

Components of culturally competent evaluations: Client's perspective

1. The client understands the purpose of the evaluation and how it will be used in the case.
2. The client understands the basics of the evaluation process including:
 - what a psychological evaluation is, how it is to be conducted, and the limits of confidentiality;
 - who will be involved, how long it will take, and what is expected of the client during the evaluation;
 - what the role of the clinician is during the evaluation, what type of information will be gathered during the evaluation, what type of information is important for the client to communicate and contribute, and who will be informed about the results of the evaluation.
3. The client understands the procedural format of the evaluation, including whether or not the evaluator will incorporate the use of short questions and answers, personal stories and narratives, or historical or developmental sequences presented in chronological order, or the use of psychological or intelligence tests (if appropriate), and whether or not collaterals will interviewed and who they will be. Will the client be asked to give his or her perspective on their case and recall events and situations pertinent to the case?
4. The client understand the end result of the evaluation, including how the information that is communicated during the evaluation will be used to formulate opinions and reports; what the final product of the evaluation will look like (written report); deposition, testimony, and the like, what the possible outcomes of the evaluation are – how it may or may not be used in the client's legal case; and how the information may be of use to the client on a personal level.
5. The client is allowed to represent him/herself and his/her story in a manner that is consistent with the cultural context and congruent with his/her individual and cultural communication style.
6. The client feels that the clinician is sensitive to the dynamics of race and culture in the evaluation and in the legal case.
7. The client feels that the clinician is working to address barriers that may prevent openness and trust in the context of the evaluation.

- 8. The client feels that he/she is being understood, respected, and accurately represented, with freedom from stereotype, prejudice and cultural bias.
- 9. The client has faith in the competence and integrity of the evaluator.
- 10. The client understands the final results of the evaluation, believes that he/she may gain some benefit from the evaluation, and is not harmed by the process of the evaluation.
- 11. Although the client may object to the evaluation, or to its outcome, the client feels as though he/she has been treated with respect by the evaluator.

Components of evaluations from the clinician's perspective:

The clinician:

- 1. develops knowledge and understanding about the cultural background of the client;
- 2. is able to establish that the client has a clear and accurate understanding of the purpose and process of the evaluation – why it is being conducted, who has requested it, and how it will be used in the case;
- 3. is sensitive to the influence of race and culture in regard to the client's ethnicity, personality, behaviour, family and community life, and socioeconomic and political circumstances;
- 4. attends to dynamics of Sociocultural trust and mistrust on the part of the client as related to the evaluation process, and feels that the client has faith in his/her professional expertise and integrity;
- 5. finds that the clients is attempting to communicate the information that is needed for the evaluation and is actively participating in the evaluation process;
- 6. is able to present information to the court that as accurately as possible represents the identity, behaviour, and personality of the client, in the context of culture, inclusive of pertinent socioeconomic and political dynamics, and free of bias and stereotypes;
- 7. completes the DSM-IV-TR Outline for Cultural Formulation;
- 8. succeeds in addressing the legal questions and goals that are integral to the evaluation's purpose;
- 9. explains the results of the evaluation to the client and is able to make appropriate referrals or recommendations to assist the client with social, institutional, mental health, or emotional difficulties; and
- 10. if appropriate, can offer suggestions to the attorney that may facilitate his/her work with the client.

2. Study: Daniel et al., 2004: Individual and cultural-diversity competency in knowledge, for clinical psychologists (USA).

1. The growing and multidisciplinary theoretical and empirical literature on the topic of therapy with culturally diverse individuals;
2. that there is more than one way to conceptualise and deliver diversity-sensitive service, and that at this point there is no evidence suggesting that one perspective is more effective than another;
3. that diversity perspectives do not supplant a theoretical and technical approach to helping;
4. that these perspectives all suggest that race, ethnicity, sexual orientation, and issues of age are dynamic and thus present and operate within the therapy session;
5. that these perspectives address an important common factor in diversity-competent therapy, namely core conditions of safety, support, rapport, and the relationship; and
6. the interesting fabric of personality, which includes individual, cultural, GLB, age-related, and universal components.

3. Study: Chew-Graham *et al.*, 2002: Suggestions for improving mental health services for Asian women and recommendations to primary care trusts (PCTs). (UK)

1. Explicitly acknowledge the impact of systemic issues on mental distress, attempted suicide and self-harm.
2. Recognising different ways in which Asian women might communicate mental distress.
3. Being alert to the fact that Asian women may access services at crisis point, and therefore, require a rapid response.
4. Providing information and advice to address external pressures; for example, benefits, children's issues, education and employment.
5. Gathering good-quality information about domestic violence services targeted at Asian women.
6. Emphasising confidentiality, and providing safe and secure services for Asian women to access one-to-one support.
7. Monitoring, evaluating and reviewing interpreter provision in relation to access to health service provision for Asian women.
8. Face-to-face promotion of services, in a variety of languages and formats, to Asian individuals, groups and organisations.
9. Providing first-language services to Asian women to overcome barriers to interpreter provision.
10. Developing facilitated self-help groups for Asian women.
11. Effective partnership working with specialist organisations committed to providing support to Asian women (e.g. Asian women's refuge).

Communication issues

1. PCTs need to highlight the particular needs of South Asian women within their population of practices.
2. Dissemination of information to practices about existing resources

Service developments

1. Awareness that Asian women access services at crisis point and require and immediate, active response.
2. Proactive development of first language services to allow Asian women to overcome barriers to interpreter provision.
3. Development of PCT-wide specialist counseling services.

Training issues

1. Primary care trust led education of managers, professionals and all practice staff, linked with clinical governance activities.
2. Supervision of clinical staff, in which gender and race issues are addressed.

4. Study: Mir *et al.*, (2001): Principles that should guide the planning and provision of learning disability services to people from minority ethnic communities. (UK)

1. Services need to take account of particular values and needs;
2. partnerships with minority ethnic groups are needed to influence local service planning;
3. the role of advocacy needs to be developed;
4. restrictive attitudes towards disability within minority ethnic communities need to be addressed; and
5. there is a need for increased participation and control for people with learning disabilities from minority ethnic communities in service planning.

Minorities within minorities: women and religious minorities in the definition of minority groups. A textual analysis of the policy *Delivering Race Equality*.

Saima Masud, Department of Psychology, Clinical Section, University of Leicester



University of
Leicester

Introduction

In this research, I am interested in the issue of how minority ethnic groups are defined and how communities are to be engaged. I am also interested in the dominant and subordinate categories within these groups and I analyse this relationship. This study is part of a wider research project on race equality in mental health care. This research comprises two key components; firstly, interviews with clinical psychologists who work in mental health services and key representatives from the policy field, and secondly, an analysis of government policy documents on this issue. In this poster, the results of the textual analysis of the policy DRE are presented.

Methodology

The analysis of the policy DRE was based on discourse analysis, drawing on Foucault's ideas about knowledge and power: 'Dominant discourses give shape to what is seen as right and wrong in society and shape the solutions which are preferred' (Murphy et al. 1998, p.128). The approach to Foucauldian discourse analysis outlined by Willig (2001) was utilised. This approach focuses on the consequences of language on social practices.

Two themes explored in the textual analysis

1) Religious minorities in minority ethnic groups: implications for community engagement

- DRE states that 'black and minority ethnic' refers to 'people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants'.
- This definition fails to identify non-ethnic criteria implying that discrimination is confined to ethnic groups (Anthias, 1990; 1992).
- Currently, Muslims experience discrimination more than any other group and this is part of a wider socio-political climate which is not confined to race and ethnicity (Modood 1998).
- For example, the impact of 9/11 and 7/7 contribute to a discourse linking Muslims with extremism and terrorism, thus increasing prejudices against Muslims and in turn the risk of increased discrimination (Modood, 2003).
- In addition, socio-economic disadvantage is stronger in the Pakistani and Bangladeshi community, the majority of whom are Muslim (Malik, 2003).
- Significantly, the Race Relations Amendment Act (2000) classes Muslims as non-ethnic religious minorities, unlike Jews and Sikhs who are classed as ethnic religious minorities.
- Against this backdrop, the relationship between Muslims and mental health services needs to be seen in terms of the extreme social exclusion of Muslims and how that might be a major contributory factor to the voluntary social isolation of some Muslims, who prefer to separate themselves from mainstream institutions. The inclusion of the experiences of Muslim communities could facilitate opportunities for those communities to intervene in public discourse about them. This could promote long-term participation in the institutions of wider society.

2) Minority women in minority ethnic groups: implications for community engagement.

- DRE recognises that some categories of minority ethnic groups suffer particular disadvantages, such as *children, older people and refugees and asylum seekers*; however, it does not include women.
- The exclusion of women implies that minority groups are homogenous and that the status of all members within the group is the same (Sahgal & Yuval-Davis, 1992).
- In community engagement, problems may stem from the fact that many groups are internally 'gendered', in that the power relations existing within the group's internal structures disadvantage women (Okin, 1998; Yuval-Davis & Anthias, 1989).
- Community discussions are often led by men and there is a feeling amongst some minority women that their views are overlooked (Anthias & Yuval-Davis, 1992; Yuval-Davis et al., 2005). Consequently, these views are excluded from discussions with services.
- The opportunity to let women's views surface and be recognised as part of the dialogue with communities could be addressed by replacing perceived homogeneity with a much wider process of consultation which recognises people's diverse positionings, as well as their ethnic identities.

Conclusion

DRE's attention to community engagement calls into question what is expected of community members and who may legitimately represent the community.

Ethnic profiling may not represent all minorities and especially not all members of a minority group. Religion is one aspect among a range of factors which makes minority groups appear different and like gender it can add a further layer of exclusion. Such processes may prevent minority group members from being active and promoting change in their communities as well as in the wider society. The need to listen to the multiple voices within groups is central here.

Appendix M

A Foucauldian Analysis of Mental Health Inequalities

The existence of health inequalities among the various ethnic groups in the UK is well established (Smaje & Le Gran, 1997), with a range of mental health outcomes appearing to vary according to ethnicity (Nazroo, 1997; NHS Executive Mental Health Task Force, 1992; Wilson, 1993). However, the precise mechanisms through which such inequalities are produced remain ill-understood (McLean et al. 2003). To see how mechanisms operate in regard to Foucault's thinking we need to start by looking at the role of language or discourse in inequalities (Willig, 2001).

Let us take the definition of minority ethnic groups established in DRE as our example. The definition 'people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants' (DoH, 2005, p.11), identifies minorities predominantly in ethnic terms. Minorities who want to be acknowledged under the protection and provisions of DRE must respond to this type of categorisation and present themselves as predominantly an ethnic group, which in Foucault's terms is how discourses are inscribed in subjectivities and normalised (Mills, 2003). Presenting oneself as an ethnic group includes both the search for 'distinctive characteristics' (such as traditional values) within one's own group, as well as the readiness to exclude the 'others' from this constructed

collective (Benhabib, 1996)⁴⁴. Put another way, the search for ethnic distinctiveness may draw upon comparisons and differences between groups⁴⁵. Stereotypes may operate by and through such distinctions.

Stereotypes of African-Caribbean people as being more dangerous and threatening than their white counterparts are said to lead to the higher drug dosages, restraint and incidence of involuntary admission to acute services that is experienced by African-Caribbean clients (Bhui et al. 2003; Boast & Chesterman, 1995; Davies, Thornicroft, Leese, Higginbotham, & Phelan, 1996; Dunn & Fahy, 1990; Littlewood, 1986; 1992, McGovern & Cope, 1991). This negative experience may be a key factor in the under-utilisation of services by minority groups (Cole, Leavey, King, Johnson-Sabine & Hoar, 1995). Failure to access support services at an early stage increases the likelihood of involuntary admission (Ineichen, 1990), thus reinforcing negative stereotypes and experiences of services by minorities, as described above.

What is being drawn attention to here, by this Foucauldian analysis, is whether the negative and unequal experience of mental health services by minorities can be accounted for by stereotypes, which may be understood to be as result of the definitional workings of those labels that are used to categorise minorities (see Figure 1 below).

⁴⁴ Benhabib (1996) argues that all types of group identities involve differentiating oneself from what one is not, so that identity categories are always and necessarily about the creation of differences. For instance, one is a Bosnian Serb to the degree to which one is not a Bosnian Muslim or a Croat.

⁴⁵ Verkuyten (1997) provides empirical evidence of comparison processes in the construction of minority ethnic identity.

Appendix M

Figure 1: Map of the (re)production of inequalities informed by Foucauldian analysis

