Chapter 2

Ethnic and cultural effects on mental healthcare for women

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Introduction

Gender plays a major role in cultural perceptions and likelihood of diagnosis in mental illness. For women, there is often a "double-jeopardy" at play. First, many psychiatric disorders are more common in women; second, women are predominantly the caregivers across cultures, adding further difficulty and demand to their lives. For Black and minority ethnic (BME) women, there are additional dimensions related to ethnic and racial status.

In this chapter, we begin by defining the key terms "ethnicity" and "culture" before exploring relationships between ethnicity, culture and women's mental health. Using an intersectional framework, we examine the greater prevalence of common mental disorders among women and the social, ethnic and cultural concomitants of their mental health. We conclude by examining implications for mental health practice, policy and research.

Ethnicity, race and culture

The terms "ethnicity," "race" and "culture" are frequently used synonymously and interchangeably in both psychiatric epidemiology and clinical practice. However, although related, there are important differences between these concepts.

Ethnicity is commonly used to denote a system in which "ethnic group" members identify and are identified on the basis of shared characteristics such as ancestry, language and political or ideological nationalism, which set them apart from other groups. Whilst closely associated and overlapping with "race," the concepts differ in that "race" refers to biologically inherited and physically differentiating characteristics, such as skin color. Therefore, although "race" is sometimes used to highlight common genetic characteristics of all people, as in "the human race," the concept is usually deployed to emphasize perceived immutable, hierarchical differences between groups. In many cultures, skin color plays a significant role in people's social acceptance and ascribed social roles. Thus, skin color may be used as a shortcut, or cultural stereotyping, for attributing certain values and attitudes, which become further complicated by the gender of the individual.

Ethnicity is best self-ascribed (Smaje 1995). Individuals can choose the categories to which they belong and, depending on individual preference and context; ethnicity can be fixed or fluid, displayed or hidden, unlike visible phenotypic differences. In a mental health context, this is important as, despite scientific evidence for human homogeneity at a global level, the tendency to attribute hereditary causes to profound inequalities in mental health has proved stubbornly persistent (Fernando 2009). This is not to imply that biological differences do not exist. For example, in relation to physical health, there are a number of conditions that exclusively affect particular groups such as sickle cell anaemia in people of African descent and thalassemia amongst Mediterranean peoples. However, the relationship between ethnicity, culture and mental health, which is the focus of this chapter, is much less straightforward and far more highly contested. Mental illness is rooted both in the individual ***and*** in society – in biology ***and*** culture, giving rise to differing explanatory models; the understanding of which is fundamental for the provision, delivery and evaluation of effective mental healthcare (Bhui et al. 2002, Fernando 2009).

Race is a hegemonic construct. Widely deployed by colonizers in the nineteenth century, the term holds

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both biological and power connotations that allowed some groups to have power and control over others by virtue of perceived racial superiority. As a result of scientific discredit and social opprobrium of related terms "racist" and "racism," to some extent, "race" has been subsumed into the more sociopolitically acceptable "ethnicity" – a sociological and anthropologically derived concept (Fernando 2009). As people have become more mobile, whether through choice or forced migration, the result of globalization is that Western societies in particular are becoming increasingly multiracial/multiethnic. In these societies, especially Europe, North America and Australia, ethnicity, in the context of mental healthcare and research, gains salience as an important factor for identifying illness prevalence, estimating disease burden and understanding need as a basis for planning and service delivery, as well as tackling interethnic inequalities in access, provision and outcome.

"***Culture***" is a socially constructed concept. It may be understood as a system of ideas, values, beliefs and understandings or "ways of knowing" deployed by individuals in the context of specific social networks or relationships to order and create meaning in their interpersonal interactions (Littlewood 2001). These co-constructed meanings are not self-evident, but culturally coded, derived from shared "in group" knowledge, experience, beliefs and assumptions. Consequently, those unfamiliar with the cultural codes employed by any particular cultural group might have difficulty interpreting them. This is important in relation to mental health diagnosis and treatment in two important ways. First, services might be rendered inaccessible to potential users and their families who might have difficulty decoding service culture, which may be compounded by needing to overcome language barriers. Second, the inability of services to interpret cultural codes of ethnic minority patients can hinder effective diagnosis and care delivery on the part of practitioners thus contributing to patients and carers' dissatisfaction with services for those who gain entry.

It is important to acknowledge that individuals have multiple identities, which interact with other factors to influence their perspectives significantly. Therapeutic encounters between patients and health professionals are influenced by a range of factors such as the reason, place and expected outcome of the encounters (Rogers et al. 2001). For healthcare professionals, in addition to factors such as cultural and gender identities, place of training and place of work will shape development of professional cultural identities. When the patient's experience is explored through the lens of the "clinical culture," this may add a further complicating dimension to communication. For example, health professionals may be unaware of the effect of their "taken for granted" assumptions and interpretations on their interactions with patients. Perhaps more importantly, the individuals' cultural identities, gender, education, socioeconomic status and worldview contribute to social distance between parties on both sides of the therapeutic alliance (Fung & Lo 2012). (Also, see Chapter 1 for discussion of power in relationships.)

Almost two decades ago, Lloyd (1998) and colleagues reported that, in a study of African-Caribbeans consulting UK General Practitioners (GPs), there was little shared "understanding" between patient and physician as, despite using the same words, the meanings attributed to them differed between patient and practitioner causing dissatisfaction on the part of the patient and potential misdiagnosis by the GPs who were unaware of how comprehensively they had misinterpreted the interaction (Lloyd 1998). A recent study into the influence of race on doctors' decision-making in relation to diagnosing depression among African-Americans and African-Caribbeans in the UK, suggests little has changed (Adams et al. 2014). In these encounters, what is often overlooked is that it is not only the patient who has culturally specific, "culture-bound" ways of understanding and reporting mental illness. Practitioners, usually powerful members of the dominant culture, also have their own encoded ways of conceptualizing and reporting mental illness (Lipsedge & Littlewood 2006).

Neither cultures are fixed entities. Rather they are fluid, influencing their members and in turn being influenced by them. They are contextually responsive; constantly being reinvented and reinterpreted (Hall & Carter 2006). In this context, every emergent culture can be viewed as a strategic solution to a particular set of material circumstances. This can be seen in urban "ethnic colonies" at the heart of most major Western cities, which have emerged in response to the marginalization and exclusion of migrants. Instead of assimilation, many "South Asian," Chinese and Caribbean post-war settlers and their locally born children cluster together within tight-knit ethnic communities, organizing their lives according to the traditional values and norms of the countries from which they migrated.

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Whilst there is some between-group variation, there is increasing evidence that living in areas of high ethnic density is protective of the mental health of some ethnic groups (Das-Munshi et al. 2010). In contrast, it appears that acculturation might increase their risk of mental illness (Morgan et al. 2010).

However, ethnic and cultural minorities come under pressure to integrate and adapt to what the majority society determines is acceptable. Different societies have adopted a variety of approaches. In the USA, for example, the notion of a "melting pot" has had a major impact on the identity of migrants; the UK regards itself as a "multi-cultural society" (Hall & Carter 2006). In Canada, the idea of a "rainbow nation" has been developed even though the tendency to homogenize minority groups persists (Fung & Lo 2012). In Australia, cultural classification has sometimes been on the basis of ability to speak English. Following the US example in terms of labeling ethnic groups, successive generations in the UK have adopted hyphenated identities such as "Black-British," "British-Pakistani" or "British South Asian" to indicate membership to both country of birth/residence and ancestry. These "hyphenated identities," which serve as ethno-cultural signifiers, also highlight inherent tensions in belonging to both dominant and minority cultures whose competing values and beliefs can be detrimental to individuals' mental health.

Resultant tensions and the potential for "culture confusion" or "cultural schizophrenia" might have profoundly negative effects on the mental health of ethnic minorities in general, and minority women in particular (Littlewood 2001). According to Hofstede (2001), cultures have various dimensions such as egocentric versus sociocentric, feminine/masculine, distance to the center of power, uncertainty avoidance and long- or short-term orientation. However, not all members of an egocentric culture are likely to be egocentric in the same way that not all members of sociocentric cultures are sociocentric (Hofstede 2001). Thus, therapeutic interactions must become more intricate and complex if they are to be effective in terms of cultural relevance. For example, it has been noted that egocentricity and a focus on individual rights, freedom and autonomy are central features of most contemporary Western cultures. However, in more sociocentric cultural traditions, such as South Asian and Chinese communities, egocentrism might be regarded not only as counter-cultural, but as deleterious to social relationships and the collective reciprocities inherent in kinship ties based on mutuality and security. In such communities, personal needs and freedom are usually subordinate to family and group loyalty (Mawani 2008). It has been postulated that sociocentric individuals, especially if they are isolated in egocentric cultures, without members of their cultures around them may experience certain psychiatric illnesses (Bhugra 2005, James et al. 2010). As cultural values and attribution influence illness models, thus determining what is regarded as illness (or not), and culturally sanctioned forms of help-seeking, this has important implications for service provision and individuals' ability to receive appropriate care (Brown et al. 2010, Edge & Rogers 2005).

In addition to cultural values, the potential for "culture clash" between "modern" and more "traditional" cultures as well as between individuals who may feel caught between two cultures appears inevitable (Bhugra et al. 2011). Evidence suggests this is more likely to be an issue for migrant women who may carry the responsibility not only for maintaining their own culture's values, but are also expected to impart these to their children whilst needing to modify their gender roles in line with the new cultures (Baya et al. 2008). This discrepancy between gender roles and gender role expectations might go some way to explaining some of the higher than expected rates of self-harm, suicide and para-suicide among South Asian women in the UK (Bhugra 2004).

Researching ethnicity, culture and women's mental health

Many psychiatric conditions have higher rates in different ethnic groups and cultures. A lack of space does not allow us to go into details here. For a helpful review see Kirkbride and Jones (2011). However, using research tools developed in Western societies to measure mental health variables across groups without acknowledging the potential for "category fallacy" in the resultant epidemiological data is problematic. Furthermore, understanding cultural variation is crucial if therapeutic encounters are to be engaging and fruitful (Venkatapuram 2011). It is beyond the scope of this chapter to explore the reasoning behind and the functions of psychiatric diagnosis. Suffice to say that, whilst diagnosis facilitates understanding of the health needs of populations, the "new epidemiology" must take into account multiple factors in making sense of individual experience (Venkatapuram 2011).

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It has been argued that higher rates of mental illness in women might more accurately reflect the process of detection and diagnosis than the presence of illness (McMullen & Stoppard 2006, Stoppard 2000). This gains particular salience when dealing with women from minority backgrounds. From a social construction perspective, diagnosis results from the encounter between clinician and patient in which what counts as mental illness is negotiated within a wider social context (Rogers et al. 2001). This means that what is regarded as mental illness in any particular place or time is neither constant nor fixed, but rather is influenced by sociopolitical forces (Metzl 2009). Exploring the distinction between disease (which is pathology) and illness (which is the social expression of underlying distress and may or may not be directly related to pathology), it is important to recognize that onset of an illness cannot always be understood in terms of direct causation. A "web of causation" has been defined as a potential way forward (Joffe et al. 2012). This model indicates that a series of factors directly and indirectly affect the development of disease and its outcomes. Combined with cultural variations in idioms used to express distress (see Chapter 1), there arises a major challenge to researchers and clinicians alike for diagnosis and investigations in relation to the mental health of minority women.

Culturally influenced gender stereotypes of mental illness exist, providing a variety of images, labels, definitions and templates for conceptualizing what counts as normal or abnormal behavior, as mental illness (or not) and a related repertoire of behaviors ascribed to someone who is deeply distressed or disturbed. In this context, Scheff and colleagues have theorized that society operates according to "residual rules" (Scheff & Brown 2002). Whether an individual's residual rule breaking is referred to an "elder," to police or to psychiatrists can be determined by a number of factors, including resources, levels of tolerance in community and social distance between the rule breaker and agencies. Persons of lower social status, those with less supportive families or social networks and the most marginalized may be more likely to be labeled and responded to as if mentally ill when residual rule breaking becomes public (Metzl 2009). These factors influence whether or not unusual behaviors are categorized as psychiatric symptoms, deviance or something altogether different, such as a legitimate ethno-cultural or spiritual response. Even in the twenty-first century, women and ethnic minorities disproportionately occupy low-status, low-power positions, which not only increases their vulnerability to mental illness and mental illness diagnosis, but also increases the risk of their responses to trauma, neglect and abuse being medicalized, criminalized or both (Cermele et al. 2001, Rogers et al. 2001) (See Chapter 1).

In this context, there is also often a discrepancy between what is expected of women with conflict between gender role expectations and women's own needs and expectations. Such discrepancies can cause emotional distress that may lead to psychiatric disorders (Bhugra et al. 2011). For ethnic minority women there are additional difficulties, which include experiences related to racism and misogyny in certain cultures that can exacerbate vulnerability to mental illness. However, social and cultural expectations that they prioritize the needs of their families and members of the wider community are further compounded by explanatory models of distress, thus impeding help-seeking – especially from formal mental health services, which might be regarded as socioculturally inappropriate (Edge & Mackian 2010). For example, where mental illness in general, and depression in particular, is seen as a valid response to life's "ups and downs," help is more likely to be sought from nonmedical sources if at all (Edge & Rogers 2005). Furthermore, minority women highlight the role community-level stigma plays in preventing them seeking help (Nadeem et al. 2007).

Nevertheless, in common with others, minority women seek help more readily both for themselves and others in comparison with men (Collins et al. 2008). However, in certain settings, help-seeking is heavily influenced by language barriers. Women may be accompanied to consultations by men who may choose to speak on their behalf. Sometimes children may be asked/expected to interpret for their mothers and sisters. This is both clinically and ethically questionable in all general medical consultations, but all the more problematic for psychiatric conditions – especially where sexual violence is a feature. These encounters might therefore create further tensions for women, exacerbating their distress and resulting in behaviours such as denial and avoidance. The result is that many ethnic minority women experiencing psychological distress fail to receive timely and appropriate diagnosis, care and treatment.

We now provide a brief overview of studies among minority women to illustrate some of these issues. To do so, we focus on three areas that are particularly germane for highlighting the problems

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specific to the mental health of minority women: depressive illness, gender-based violence and migration.

Depressive illness

The evidence on depression among minority women is inconsistent. For example, in relation to perinatal depression, the global prevalence is agreed to be around 15% (O'Hara & Swain 1996). However, this masks significant inter- and intra-ethnic differences. To illustrate, in a recent study among Israeli Arab women in northern Israel using the Edinburgh Depression Scale (EPDS) (Cox et al. 1994), 20.8% and 16.3% scored above threshold (EPDS $\geq$10) in the antenatal and postnatal periods respectively. Rates of postnatal depressive symptoms were significantly higher among Moslem compared with Druze women (19.0% vs. 13.4%; p = 0.01); higher than previously reported for Jewish Israeli women in the same region (Fisch et al. 1997), but considerably lower than among Arab Bedouin women (43% at the EPDS $\geq$10 and 26% $\geq$13) in southern Israel (Glasser et al. 2012).

As space precludes exploration of all minority groups, we contrast two visible minority groups to highlight sociocultural factors and likelihood of being diagnosed with depression and perinatal depression (see Edge 2011b for useful review of perinatal mental healthcare for minority ethnic women, highlighting shortcomings in service provision and the need for research among minority women, including white and "hidden" minorities such as Irish and traveling communities). In the UK, researchers report depression rates of 30% and above among British Pakistani mothers, which appears to take an atypical course with a tendency to become chronic and to be associated with both physical ill-health and other psychological problems (Gater et al. 2010). This may reflect alternative conceptualizations, explanatory models and expression including presentation with somatic symptoms caused by underlying psychological factors, which may not be picked up by mental health professionals.

South Asian women's social isolation, being overly controlled by their families and poor literacy are factors that have also been identified as potential contributors to increased risk of depression. In south India, in the region of Kerala, the literacy rate is over 98% among women, yet suicide rates are the highest in the Indian nation. This phenomenon has been linked to discrepancies between achievement and aspiration of highly educated women, many of whom find it difficult to find work or come under social pressure not to work after marriage (Government of India 2008). Discrepancy between women's aspirations and their lived experience as a potential trigger for depression is also implicated in findings from the UK that rates of depression among Pakistani and Bangladeshi migrant women become even higher when they start to speak English (Gask et al. 2011). However, this might not be indicative of increased prevalence *per se*. Rather, acquiring the ability to speak English provides women with the means of conceptualizing and expressing their feelings as depressive symptoms. Language acquisition for this and other migrant groups might afford better understanding of the healthcare system and increase women's likelihood of seeking help and receiving a diagnosis.

In contrast to South Asian women, who are stereotypically regarded as passive and therefore depression-prone, Black women are frequently seen as strong and aggressive, characteristics that are at odds with perceptions of depressed individuals (Edge & Rogers 2005). There is evidence that Black women internalize these views, often minimizing depressive symptoms or regarding them as a reasonable response to adversity (Beauboeuf-Lafontant 2008, Edge 2008). Consequently, these women reject depression as an existent condition among Black women, seeing it as a "White woman thing" and a sign of moral weakness (Edge 2007). This might at least partly account for low rates of diagnosed depression in Black women. It has long been noted that, in contrast to elevated rates of psychotic illness, depression rates among some Black and ethnic minority groups in the USA and UK are significantly lower than the majority communities (Williams et al. 2007). However, community-level screening in the UK (Nazroo & Sproston 2002) and research among Black women elsewhere indicates higher-than-average levels of depression and consequent untreated morbidity (Brown et al. 2010). For example, perinatal depression rates in excess of 25% have been reported among Black Brazilian (Da-Silva et al. 1998), South African (Lawrie et al. 1998) and Jamaican (Pottinger et al. 2009) women.

This growing body of evidence has led some commentators to suggest that, in addition to cultural and social barriers to help-seeking (Edge & Mackian 2010), low rates of diagnosed depression in Black women might also reflect diagnostic bias and

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diagnosticians' often unconscious but deeply held views about the association of certain categories of mental illness with particular groups of people. As rates of diagnosed depression among people of African descent do not reflect community levels (Sproston & Nazroo 2002), it has been suggested that clinicians' perceptions of depression as a white Western illness, requiring levels of introspection and emotional literacy available only to those occupying higher biological and social roles, precludes diagnosis in people of African descent (Metzl 2009). Instead, African Diaspora women may be regarded as more vulnerable to undifferentiated "primitive psychoses" coupled with a tendency towards violence, "conversion hysteria" or somatic disorders resulting from limited self-exploration and ability to express emotions linguistically and consequently less likely to be diagnosed with depressive illness.

In summary, Black women's mental health tends to receive little attention despite paradoxical findings of low rates of diagnosed depression and suicide despite higher rates of psychosocial risk. In contrast, there is increasing research into South Asian women's mental health, which has become synonymous with depression, suicide and self-harm. There is evidence that this might be because stereotypical views of Asian women as passive, insular and overcontrolled more readily equate with illnesses that are often regarded as resulting from "turning in on oneself." In contrast, Black women do not readily conform to the stereotypical picture of depression. This might have given rise to a belief among clinicians that Black women do not experience depression and/or self-harm. However, emerging evidence suggests that this is not the case. Not only do they experience high levels of undiagnosed and, therefore, untreated depression, they also have higher rates of self-harm than either White or South Asians, but may be less likely to receive psychiatric assessment (Cooper et al. 2010). Their absence from epidemiological data is a serious omission as research from the Caribbean suggests that suicidal behaviour and deliberate self-harm have raised serious public health concerns (Hutchinson et al. 2008).

Gender-based violence

Gender-based, interpersonal violence, although seen as a social problem, has important consequences for health (see Chapter 14). Evidence indicates that minority women are especially vulnerable to interpersonal violence. Rape and its traumatic sequelae have serious implications for women's mental health, often leading to depression, post-traumatic stress disorders (PTSD), other psychiatric disorders and problems with intimacy. In a US study, 31% of all rape victims developed PTSD. Nearly one-third (30%) of women who had been raped developed at least one major depressive episode in their lifetimes with a similar proportion (33%) reporting suicidal ideation (Kilpatrick 2000). These figures gain particular salience when related to women of color. For example, high rates of child sexual abuse (CSA: defined as incest, rape or sexual coercion before age 18) have been documented in community samples of Black women recruited from Boston (34.1%) and Chicago (65%). In adulthood, 22% of the Black women in the National Intimate Partner and Sexual Violence Survey (NISVS) reported that they had been raped at some point in their lives. The NISVS also revealed that 41% of Black women experienced some form of sexual coercion or unwanted sexual contact. These prevalence rates translate to an estimated 3.1 million Black rape victims and 5.9 million Black survivors of other forms of sexual violence. Persistent stereotypes of Black women's sexuality, rooted in slavery and colonialization and women's inability to pay for high-quality support, contributes to an unsympathetic service response thus deterring women from seeking help and increasing the likelihood of chronic mental health problems (West & Johnson 2013).

Intimate personal violence is multidimensional and incorporates narrow as well as broad definitions creating epidemiological data that are not entirely comparable. Narrow definitions produce lower rates and broader definitions higher rates. A World Health Organisation (WHO) multination study from 15 centers in 10 countries, reported that life time prevalence of physical or sexual violence for ever-partnered women varied from 15% to 71% (WHO 2013). A 12-month prevalence rate varied from 4% to 54%. Among ever-partnered women in the population rates of physical violence varied from 4% in Japan to 49% in Peru (Howard et al. 2013). As the research in this area is still emerging, the correlates of gender-based violence and ethnic minority status are yet to be theorized. However, forced and arranged marriages, social isolation (especially when coupled with language barriers), low socioeconomic and educational status, which make women more vulnerable

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to being controlled by men, are likely to be among crucial factors. For women from collectivist cultures, where patriarchal ideology emphasizes the dominant role of the husband or father and subordination of individual views or needs in favor of family/kinship ties, women may be understandably reluctant to disclose intimate partner and/or sexual violence – especially as doing so risks ostracism and stigma not only for women but also their children and extended families (Mason & Hyman 2008). Accordingly, good practice suggests that partners, friends and family members should not be used for interpretation when these women access services (NICE 2014). Wherever possible, professional female interpreters should be used and information and educational leaflets should be available in both relevant languages and non-language-based formats (Agnew-Davies 2013, Trevillion & Agnew-Davies 2013). Also see Chapter 14.

Female genital mutilation (FGM) is common practice in many non-Western cultures and specifically affects women from minority backgrounds. Most Western societies are ill-equipped to deal either with the act or the process by which it is brought about, for example, girls being taken abroad to undergo FGM. Although there are no robust epidemiological data, the available evidence suggests that the scale of the problem is significant. In the UK, a Department of Health–funded project reported that, in 2001, there were almost 66,000 women living in England and Wales who had undergone FGM with a further estimated 16,000 girls under the age of 15 at high risk (Dorkenoo et al. 2001). In the absence of good quality evidence, the long-term impact of FGM cannot be estimated although anecdotal evidence suggesting potential problems with both physical and psychological aspects of childbirth such as increased vulnerability to perinatal mental illness and women being retraumatized. FGM is a reflection of social attitudes to sex and female sexuality among some cultural groups. In these cultures, it is not uncommon for women also to undergo hymen reconstruction in order to be perceived to be virgins at the time of marriage. This process further distorts evidence of the true extent of sexual violence against women including the possibility that many of these women may have been raped or be victims of incest (WHO 2013). Research is urgently needed better to elucidate the scale of the problem, understand the impact on women and girls, and inform appropriate service development and delivery.

Trafficking also particularly affects minority refugee and asylum-seeking women. Accurate data for rates of psychiatric illness among affected women are not available as women who have been trafficked are often underrepresented in studies. The problems they face are still not fully understood but it is clear that trafficking, forced prostitution, sexual abuse and being rendered stateless can all lead to a range of psychiatric problems. These factors contribute to poor mental health, which WHO cites as the dominant and persistent adverse health effect of human trafficking. Specific psychological sequelae include depression, PTSD, anxiety disorders, increased risk of suicide and somatic conditions including disabling physical pain and dysfunction. Additionally, there is increased risk of co-morbidity among victims of sex-trafficking. Forced or coerced use of drugs and alcohol as a means of controlling individuals and increasing profits is frequently reported, and victims might use drugs and alcohol as means of coping with being trafficked (WHO 2012).

Chandra (2011) points out that increasing numbers of women are migrating and it is likely that migration itself has a differential effect on women compared to men. She describes specific mental health difficulties for domestic workers in various countries that may lead to exploitation – physical and sexual – and enforced cultural isolation. Furthermore, disparity between aspiration and achievement may well affect their self-esteem and increase risk of depression.

Sexual and other forms of gender-based violence and exploitation affect all women. However, Black and ethnic minority women are particularly vulnerable. Although all women who have experienced violence, including rape and being trafficked, will have some difficulties in common; assessment and intervention needs to take cultural aspects into account. Women should be interviewed in private with a female chaperone, if necessary. Clinical assessment should include thorough questioning about financial independence, support networks, confidants and views about family honor as these will provide insight into the kinds of help and support that affected women are likely to find acceptable. Ideally, specifically trained, culturally competent therapists and appropriate services should be commissioned to meet the particular needs of women affected by gender-based violence. See also Chapter 14.

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Migration

At the outset, it is important to acknowledge the heterogeneity of migrants. Whilst some migrants enter new countries by choice and/or active recruitment by others on the basis of their skills and expertise, others are forced to do so by economic or political circumstances in their country of origin. Still others are transported as victims of trafficking. In a 2004 study of independent and sponsored migrants to Quebec, Canada, half the respondents cited the political situation in their countries as the primary reason for migration (Rousseau & Drapeau 2004). Minority women, who might have less choice in the decision to migrate because of the patriarchal nature of their countries of origin, might experience migration as a form of trauma, thus making them vulnerable to mental health problems, depression and anxiety in particular. Women who become refugees or asylum-seekers face additional stresses as a result of their migration status (or lack thereof), which means they have limited or no access to the services, rights and legal protections afforded to members of the majority population or settled migrants. Language barriers and lack of awareness of the cultural customs and norms of the countries to which they have migrated contribute to social isolation, increased vulnerability to mental health problems and challenges in accessing services (Mawani 2008).

Additionally, women's central role in maintaining family and kinship networks, including pressure to send money home and to sponsor others to join them, whilst raising their children without access to the support of extended families can be extremely stressful. Women report that these stresses negatively impact their marital relationships, especially where there are financial worries and/or women become the chief or only sources of family income, which generates tensions from reversal of gender-based roles within their culture. The possibility of divorce and family breakdown represent further stressors for women with pressure to remain in situations that are detrimental to their mental health for fear this would bring shame, stigma and potential financial ruin to their families (Chandra 2011).

Not surprisingly, women in these circumstances report lack of support (practical and emotional) and the absence of a close, confiding relationship; these are known triggers of common mental disorders such as anxiety and depression, perinatal depression in particular. For some women, their experience takes the form of "cultural bereavement" – grieving for the loss of home and shared cultural identity, which have been shown to be protective of mental health (James et al. 2010). In this context, women report facing "triple jeopardy" of belonging to marginalized communities, namely, experiencing racism, sexism and discrimination on the basis of their migrant status (Ardiles et al. 2008). The social exclusion and discrimination that both settled and migrant women face may be exacerbated by low socioeconomic status resulting from under/unemployment, low self-esteem and a sense of hopelessness emanating from perceived lack of control and powerlessness with deleterious consequences for their mental health (Mawani 2008). Clearly, these factors do not operate in isolation but overlap and intersect with each other in ways that increase minority women's vulnerability to onset of mental illness.

Ethnicity, culture and women's mental health: intersectional perspectives

The relationship between gender, ethnicity, culture and mental health is complex and multifaceted. "Intersectionality" affords a theoretical framework for examining these intersections in the specific context of minority women's mental health. Rooted in feminist and critical race theory, "intersectionality" is frequently embraced by both anti-racist and feminist scholars. Emerging in the last decades of the twentieth century, with its focus on problematizing and ultimately rejecting simple race/gender binaries, intersectionality became a powerful tool for examining and theorizing the multidimensional ways in which ethnicity and gender interact to shape Black women's experiences (Nash 2008). From a politico-theoretical perspective, intersectionality also acknowledges the existence of (multiple) socially constructed identities and seeks to understand the mechanisms by which their interaction shapes experiences of exclusion, oppression and subordination (Collins 2000). This is particularly germane for BME women who are so often "othered" by the experience of multiple forms of oppression and marginalization (Egharevba 2001, Ladson-Billings 2000).

Adopting an intersectional standpoint to scholarship and clinical research facilitates a shift away from a-contextual examinations of unidimensional variables towards alternative methodologies and ways

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of seeing (Christians et al. 2000) that allow more meaningful examination and understanding of the dynamic processes that influence individuals' lived experiences. Intersectionality encourages and enables scholars to go beyond epidemiology and other positivist approaches, actively seeking meanings beyond numeric values and "variables" such as "ethnicity" and "gender" in order to examine their impact on individuals and the various spheres that they inhabit. Intersectionality is therefore a useful heuristic for exploring the interrelationship between ethnicity, culture and women's mental health.

Examining the UK's two most researched ethnic minorities in relation to mental health, it appears that persistent stereotypes within psychiatry place Black Caribbean men and South Asian women in a binary position where the former are seen as being "out of control" and the latter as "private and too controlled" (Littlewood 2001). UK mental health service delivery and related research among Black Caribbeans, therefore, tends to focus on men and on conditions that are associated with dangerousness such schizophrenia and psychosis (Henderson et al. 2014). Mental health professionals' stereotyping of Caribbeans as "Big-Black-and-dangerous" (Ferguson 1993) means that resources are directed towards coercive interventions for men in secondary and tertiary care with relatively little attention being paid to addressing the mental health needs of Black and other minority women in primary care (Kotecha 2008).

Such perceptions might partly account for the large volume of research into perinatal depression among South Asian women. In terms of clinical practice and diagnosis, cultural perceptions and the available evidence base might sensitize practitioners to becoming alert to the possibility of perinatal depression among South Asian women, but not in Black and other minority groups (Edge 2010a, b). Specifically, Primary Care Physicians/General Practitioners (GPs) and others may regard contextual factors as influential and thus may be more likely to rely on judgments about coping and the extent to which social roles differentially affect women's mental state. This in itself may be influenced by stereotypical expectations of Black and other minority ethnic women and this may partly explain contrasting very high and low rates of depression diagnosis in such individuals despite similar psychosocial risks.

An intersectional approach is crucial, if we are to arrive at a more nuanced understanding of the differential impact of risk factors for individuals and groups of women and take these into account when developing and delivering mental health services. For example, whilst most migrant women might experience discrimination, the impact is likely to differ greatly. Racism might be experienced on three levels: institutional, personal and internalized. From this standpoint, not all minority women will experience institutional racism, the "differential access to goods, services, and opportunities of society by race" (Jones 2000), some will be shielded by factors such as skin color (for example, women migrating between European countries or North America), high socioeconomic status, education and language proficiency – factors that might also facilitate cultural understanding and acceptance by the majority population.

Indeed, although in the minority, being White Western in most non-Western countries affords women a higher status than similar women in their native countries. In contrast, minority women (particularly of African and Asian descent) are more likely to occupy low-status positions when they migrate. Lower socioeconomic status coupled with ethnocultural identities linked to the social determinants of mental illness (such as poverty and social isolation) not only place them at potentially increased risk of mental illness, but also serve as barriers to accessing care and treatment from statutory services. As a consequence, minority women's mental health provision in primary care is often delivered via voluntary sector agencies, services that rarely have long-term, sustainable funding. In times of financial constraint, these services are especially vulnerable. This is particularly deleterious to the mental health of minority women whose socioeconomic status means they are more likely than other groups to need mental health services. However, perceptions and negative experiences of services coupled with internalized racism and potential language barriers might create/reinforce fear and mistrust of mainstream mental health services (Edge 2011a, Henderson et al. 2014), rendering them inaccessible to ethnic minority women.

Conclusions

Hofstede (2001) postulates that cultures have 5 separate dimensions. For the purposes of the present chapter, we focus on his dimension of masculine and feminine cultures. Masculine cultures suggest that men in these cultures are more interested in

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earnings and career advancement whereas women see friendly atmosphere, position security, cooperation and physical conditions in their workplace as more important. Using such a "masculinity index" as a measure of national differences, he found that the role men play in high masculine index settings is very different from that played by women. These settings have higher stress, and a belief in individual decisions and work is very central, whereas in low masculine index settings almost the opposite is true. Thus, unemployment and gender role expectations will impact the mental health of minority men and women differently. In high masculine index societies, there is a strong gender differentiation in the socialization of children thus perpetuating the gender roles. Both boys and girls may learn to be ambitious (Hofstede 2001, p. 306), but the opportunities for girls to develop and achieve their ambitions are more limited. In these societies and cultures, family is important and traditional marriage concepts mean that marriages occur early and may well be arranged. There are also key differences in the work situations and behaviors, thereby creating (a sense of) male control. Thus, when women from such cultures migrate to less masculine cultures their behavior may change, creating a conflict with their male counterparts. In addition, there are clear religious and sexuality related differences. Such differences can therefore contribute to social expectations for women to behave in particular ways thereby creating additional stress.

There is no doubt that women can and do play a significant role in identifying distress among family members and seeking help for them, tending to ignore their own needs. This perspective was highlighted in the seminal work of Brown and Harris (1978) on depression. They found that women's psychological distress was often underreported because caring responsibilities meant women lacked time to seek help on their own behalf and/or were more likely to put the help-seeking needs of others above their own (Brown and Harris 1978), perhaps increasing duration of untreated illness among themselves.

Implications for policy and practice

I. Overall psychopathology must be seen in the context of cultural and gender roles and gender-role expectations. For example, among South Asian women in the UK, rates of depression are significantly higher and attempted suicide between the ages of 18–24 have been shown to be nearly 3 times those of their British counterparts. Culture-conflict is thought to play a significant role. Conflict may arise between families and women who are beginning to individuate and develop their own identities, identities that are not necessarily "traditional" or close to those held by their parents or other key members of their communities. Among migrant women, cultural bereavement may be noted, which reflects losses of place, people and property. These factors must be taken into consideration when commissioning and delivering women's mental healthcare in multicultural settings. Failure to do so might not mean only that some women fail to receive the care and treatment they need; services might also inadvertently create/reinforce perceptions of institutional racism in mental healthcare.

II. Academics, policy makers and services need to take cultural and ethnic phenomena into account when considering causation. This may mean reviewing overall rates of pathology in a population where cultural differences may be seen as "causing cultural variation" in rates and diagnoses. A major shift in clinical management and understanding also needs to occur so that the concept of a "web of causation" as described earlier is considered, rather than single factor etiological models.

III. Acknowledging and seeking to understand, the different effects of intersections between ethnicity, gender, culture and other mediating factors is fundamental to delivering services capable of meeting the needs of the range of women in a multicultural society. Such nuanced understanding in service design and delivery would not only affect the mental health of the visible minority women (those who stand out by virtue of skin color or dress), but is also important for 'hidden' minorities. For example, white Irish and European women might 'look like' the majority communities, but may have very different cultural beliefs and practices that contribute to the maintenance and restoration of their mental health. A key concern in this context is the role of spirituality and religion. This may often become 'pathologized' within mainstream mental health services. Ethnic minority communities in Western societies tend to have

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higher rates of religious adherence than the majority population; therefore, fostering alliance with major religious groups might be an effective means both of delivering mental health education and low-level interventions (such as counseling) in nonthreatening, accessible environments, as well as reducing the stigma in these communities, which represents a major barrier to women accessing care and treatment.

IV. "Culturally competent care" has been an aspiration for many mental health service commissioners and providers. Given the number of ethnic groups and increasing rates of interracial relationships, it may be time to rethink this strategy. Whilst it is crucial that services acknowledge variation in presentation and need, a move towards cultural awareness and developing "culturally capable" care might prove a more attainable goal. By "cultural-capability," we mean that practitioners should develop the skills and confidence to ask culturally relevant questions and to work with communities to take greater responsibility for managing their mental health. Various approaches such as developing cultural brokers, cultural liaison services and community interpreters have been adopted by organizations like the Centre for Addiction and Mental Health (CAMH) in Canada.

V. Whatever strategy is adapted, the most important message for service delivery is ensuring that the service user and her family are at the core of healthcare delivery with service providers taking individual cultural values into account.

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