

**Cultural Issues in Pre-Registered Mental Health
Student Nurses' Clinical Placements: An
Anthropologically Informed Critical Incident Study**

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Abstract

The aim of this anthropologically informed qualitative study was to explore the primary cultural issues in mental health student nurses' clinical placements and to explore how these issues in placements were dealt with, from the perspectives of years two and three mental health student nurses and their undergraduate university nursing educators. 'Critical incident' (Fitzgerald, 2000) focused ethnographic interviews (Spradley, 1979) were undertaken with a self-selected and purposive sample of 36 second and third year mental health nursing branch students, and 7 undergraduate mental health nursing branch educators across four nursing education centres in northern England. Member checking at descriptive and analytical levels was carried out, and these checks allowed for further exploration with the research participants to take place. Thematic analysis revealed that the primary issue to emerge from participants' 'critical incident' accounts of cultural issues in clinical placements were problems with differentiating psychopathology from culturally validated phenomena. This issue relates to the clinical anthropological concept of the 'normative uncertainty' evaluation dilemma (Good and Good, 1986), and was particularly associated with concerns around assessing the clinical significance of service users' religious beliefs, experiences, or practices. The clinical implications presented by this dilemma seemed to be exacerbated by a shortfall in culture specific knowledge, structural organisational issues, and the professional ideological orientation of the placement setting. Whilst the participants mentioned some strategies for dealing with the 'normative uncertainty' evaluation dilemma, one of the key lessons to be drawn from the 'critical incident' data is that student nurses and their colleagues in clinical placement should be encouraged to view the experiences of their service users in context. In the absence of previous empirical research on the 'multicultural clinical interactions' (Fitzgerald, 1992) of mental health student nurses, this explorative study clarifies the importance of cultural issues and the theoretical base of clinical anthropology and cultural psychiatry to mental health nursing.

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Introduction to the Thesis

Introduction

This PhD thesis describes the reported 'multicultural clinical interactions' (Fitzgerald, 1992) of undergraduate mental health nurses. The purpose of this anthropologically informed (Sobo, 2009) study was to explore the primary cultural issues which emerged in pre-registered mental health student nurses' clinical placements and how these issues in clinical placements were dealt with or addressed, from the perspectives of years two/three undergraduate mental health student nurses and their university nursing educators. In this introductory chapter, the impetus for the study, the research purpose and questions, the significance of the study, and the overall narrative of the background, methodology, and findings chapters are discussed.

The Impetus for the Study

The original intention was to explore the meaning of 'cultural competence' for undergraduate mental health student nurses. My interest in cultural competence and its implications for nursing practice was stimulated by work which I had completed for a Masters degree in medical anthropology at the Department of Global Studies, University of Sussex. The term itself has received much attention and interest in health professional (e.g., Sue, et al., 1982; Sue and Sue, 1990; Kim, 1991), nursing (e.g., Culley, 2001; 2006; Holland and Hogg, 2010) and policy circles (Department of Health, 2005). Its essence was also vaguely defined in the 'Nursing and Midwifery Council Code of Professional Conduct' (2008), which stated that nurses should protect the interests and dignity of service users, irrespective of their gender, race, ability, sexuality, economic status, lifestyle, religious, and cultural beliefs. Moreover, cultural competence has increasingly been seen as a requisite for quality service provision and "good client outcomes" (Yule, 2008, p. 37).

Thus, it appeared to be an opportune moment to explore the meaning of this much debated concept and its implications for clinical practice with undergraduate mental health student nurses. However, during the early months of studying for the PhD, it became clear that the aims of the study would have to change if I was to continue

my interest in examining the role of culture in pre-registered mental health student nurses' clinical placements. After reading a considerable amount of relevant literature and speaking to a number of academics in the topic area, the impression I had gained was that there was little if any consensus about how cultural competence could be defined and operationalized into clinical practice (Kleinman and Benson, 2006; Bhui and Bhugra, 2007; Bhui, et al., 2007). In fact, 'cultural competence' still seems to be largely a theoretical concept (Fernando, 2009; Bakhsh, 2010) divorced from the lived experience of mental health services.

Furthermore, despite the critical importance of culture in nearly every aspect of mental illness, including its definition and "what constitutes 'normal', expected, and adaptive behaviour" (Fitzgerald, et al., 1997a, p. 1), the empirical base about the role of culture in the clinical work of mental health student nurses is extremely limited. To my knowledge, no empirical studies specifically have explored how the issue of culture is experienced and addressed in pre-registered mental health student nurses' clinical placements. Thus, rather than trying to understand a topic which currently may not have any real meaning (i.e., 'cultural competence') or impact at the clinical level of nursing, the starting point for exploring the role of culture in student nurses placement settings was to identify the primary cultural issues and to investigate the ways these issues were responded to in clinical practice.

Research Purpose and Questions

The aim of this study was to explore the primary cultural issues in pre-registered mental health student nurses' clinical placements and how these issues in clinical placements were dealt with, from the perspectives of years two/three undergraduate psychiatric student nurses and their university nursing educators. It explored the 'critical incident' (Fitzgerald, 2000) narratives of pre-registered mental health student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992), and presents the cultural issues which the research participants viewed as important. By focusing on how these cultural issues in placement settings were dealt with or addressed, this research also presents the perceived needs of pre-registered mental health student nurses engaged in 'multicultural clinical interactions' and suggests strategies that will begin to meet those needs. The generation of 'critical incident' data and the thematic

analysis centred on providing answers to the following two research questions: 1) what are the primary cultural issues in pre-registered mental health student nurses' clinical placements? 2) How are the primary cultural issues in pre-registered mental health student nurses' clinical placements dealt with?

Significance of Study

An almost exclusive focus of empirical research to date has been on the perspectives of registered nurses engaged in cross-cultural clinical encounters (e.g., Murphy and Clark, 1993; Osborne, 1995; Baldonado, et al., 1998; Kim, 1998; Spence, 1999; Boi, 2000; Gerrish, 2000; 2001; Cioffi, 2003; Narayanasamy, 2003; Ozolins and Hjelm, 2003; Cortis, 2004; Gerrish, Chau, Sobowale and Birks, 2004; Cioffi, 2005; 2006; Hultsjo and Hjelm, 2005; Berlin, Johansson and Tornkvist, 2006; Vydellingum, 2006; Peckover and Chidlaw, 2007; Pergert, Ekblad, Enskar and Bjork, 2007; Pergert, 2008; Tuohy, Mccarthy, Cassidy and Graham, 2008; Berlin, 2010). Indeed, studies which have explored the clinical interactions of undergraduate student nurses in cross-cultural situations (see Gerrish, Husband and MacKenzie, 1996; Lundberg, Backstrom and Widen, 2005; Jirwe, 2008; Jirwe, Gerrish and Emami, 2010) are extremely rare. Moreover, to my knowledge, no studies have specifically explored these kinds of clinical encounters in the context of mental health student nursing. Whilst some cultural issues can be expected to arise across the different undergraduate nursing specialisms, each specialism may present specific issues and challenges for students working in that particular area. Therefore, this study broadens the understanding of and focuses on pre-registered mental health student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992) in placement settings.

The hope is that this explorative research will clarify the importance of cultural issues and clinical anthropology to mental health theory and practice within undergraduate nursing programs. This may then help to set the foundations for informing the clinical practice of student nurses in mental health service settings. Furthermore, as student nurses work in the context of the multidisciplinary mental health team (Bonham, 2004), the study findings may not only be of relevance to mental health nursing, but also other professional groups. Few if any of the findings are exclusively relevant to

the clinical practice of mental health student nurses. Many of the 'critical incident' (Fitzgerald, 2000) stories which the research participants shared with me involved people from other mental health professions and disciplines. Culturally appropriate healthcare is something that should concern all those working in the 'professional sector' (Kleinman, 1978; 1980; 1984) of mental health services.

This study also moved away from the traditional research focus on nurses' encounters with service users from specific minority ethnic or immigrant backgrounds. Rather, the expectation was that the research would reveal some broader insights into 'professional' understandings of health and illness and the clinical interaction (Lambert and Sevak, 1996; Carpenter-Song, Nordquest Schwallie and Longhofer, 2007). In this research project, all mental health student nurses' clinical encounters with service users were conceptualised as 'multicultural clinical interactions' involving the multiple interplay of cultures, medical systems, and frames of reference (Tebbutt and Wade, 1985; Hoeman, 1989; Fitzgerald, 1992; Fitzgerald, et al., 1997a).

Structure of the Thesis

Foundations (Setting the Scene)

Background chapters 1, 2 and 3 focus on the philosophical, theoretical and conceptual underpinnings of the research. The first background chapter provides a discussion of the constructionist philosophical perspective; the meaning-centred medical anthropological approach (Good and Good, 1981); an understanding of the important, but contested concepts of culture and family; a definition of clinical placement; and a detailed examination of Arthur Kleinman's (1978; 1980; 1984) 'health care systems model' and Maureen Fitzgerald's (1992; 2000) related concepts of 'multicultural clinical interactions' and 'culture general competency'. I make the case that pre-registered mental health student nurses' clinical interactions in placement settings involve the interplay of multiple cultures (Fitzgerald, 1992), medical systems (Kleinman, 1978; 1980; 1984), and frames of reference (Tebbutt and Wade, 1985).

In background chapter 2-‘Disease-Illness Perspectives, Explanatory Model (EM) Transactions, Conceptions of Self, and Multicultural Clinical Interactions’-I describe how key concepts from the meaning-centred medical anthropological paradigm can inform the interpretation of pre-registered mental health student nurses’ encounters with service users in clinical placement. This involves a discussion of the ‘etic’ and ‘emic’ perspectives (Skultans and Cox, 2000); the anthropological distinction between ‘disease’ and ‘illness’ (Eisenberg, 1977); conceptions of ‘self’ (Seeley, 2006); the concept of ‘explanatory model’ (Kleinman, Eisenberg and Good, 1978); ‘cultural theories of illness’ (Helman, 2000; 2007); the problematic clinical concept of ‘insight’ (Saravanan, et al., 2004; Jacob, 2010); and a critique of the ‘explanatory model’ construct.

The final background chapter (3)-‘Abnormality or Normality: The Normative Uncertainty Evaluation Dilemma’ (Good and Good, 1986)-is concerned with the major difficulties that mental health practitioners face when having “to determine whether particular behaviours or forms of experience are abnormal and therefore a symptom of illness or simply different but normal within the patient’s own cultural context” (p. 11). This chapter was included at a much later date than the two previous background chapters. In particular, I carried out additional research on this subject, as it became clear that the issues arising from the ‘normative uncertainty’ evaluation dilemma was a central theme of participants’ narratives. A review of this research is contained within separate but overlapping sections of this background chapter. These sections include: a definition of religion and spirituality; a discussion of the ‘culture’ or ‘psychopathology’ clinical dilemma and the pathologisation of religion in mental health service contexts; a description of the ‘normative uncertainty’ evaluation dilemma and the ‘category fallacy’ error (Kleinman, 1977; 1988a); and an understanding of the relationship of spiritual/religious issues with matters of diagnosis and assessment. The final sections contextualise the ‘normative uncertainty’ evaluation dilemma within the rationality and cultural relativism debate (Hollis and Lukes, 1982) and the criteria for evaluating ‘abnormality’. However, it is noted that the ‘absolutist’/‘universalist’ (rationalist) (Offer and Sabshin, 1966) biomedical model dominates the professional sector of mental health services in the UK today. These three background chapters set the scene for the chapter on methodology and provide important context for the findings chapters.

The Methodological Direction

Chapter 4 gives an in-depth description of the anthropologically informed research design (Sobo, 2009) and the qualitative strategy used in the study. Stories are integral to culture (Kleinman, 1988b; Mattingly, 1998a; b) and its understanding, and they are the mainstay of what anthropologically informed research collects and analyses. Participants' storied accounts of pre-registered mental health student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992) was based on 'critical incident' narratives (Fitzgerald, 2000). 'Critical incidents' are a subset of the narrative technique (Aranda and Street, 2001; McCance, McKenna and Boore, 2001; Schaefer, 2002); and this study drew on Fitzgerald's (2000) adaptation of Brislin and colleagues' (Brislin, 1981; 1990; 2000; Brislin, Cushner, Cherrie and Yong, 1986; Brislin and Yoshida, 1994) definition and meaning of the term.

The relevancy of the 'critical incident' approach to the study's objectives is then considered. In particular, this approach elicits meanings ascribed to specific experiences and events by guided reflection (Fitzgerald, et al., 1997a); focuses on the immediacy of experience (Fitzgerald, 2001); generates 'thick descriptions' (Geertz, 1973); and may help to uncover the tacit dimensions of clinical practice (Laws and Fitzgerald, 1997). Furthermore, the approach has shown real utility in the study of 'multicultural clinical interactions' (Fitzgerald, et al., 1997a; Arthur, 2001; 2004; Fortune, 2002; Kilshaw, Ndegwa and Curran, 2002; Whiteford and McAllister, 2006; McAllister, et al., 2006; Lovering, 2008; Yule, 2008; McAllister and Whiteford, 2008). The chapter goes on to critically evaluate the various qualitative methods by which critical incident data has been generated, and justification is given for applying the 'critical incident' (Fitzgerald, 2000) focused ethnographic interview (Spradley, 1979) to the concerns of the study.

The latter half of chapter 4 details the access arrangements, ethical protocols, recruitment of the participants, the characteristics of participants, data collection procedures, member checking and analytical strategies. Pre-registered (years two and three) mental health student nurses were self-selected from four nursing education centres attached to a university nursing school in the north of England. A purposive sample of undergraduate mental health nursing educators also was selected from the academic faculty of this University nursing school. Thirty six

transcripts of 'critical incident' focused ethnographic interviews with the pre-registered mental health student nurse participants were collected. In addition to participating in an interview, a third year student volunteered to write a critical incident narrative. Furthermore, the data set included seven transcripts of 'critical incident' focused ethnographic interviews conducted with the nursing educators.

In the interview sessions, I asked the student nurse participants to describe a particular situation they had experienced or heard about during clinical placement where they believed that culture was important to that situation. I also asked the student participants to describe how that important cultural issue in that particular situation was dealt with. Similarly, I asked the nursing educator participants to talk in depth about a particular situation where culture was an issue for a pre-registered mental health student nurse in clinical placement. In addition, the nursing educator participants described how that issue was dealt with. By using Spradley's (1979) typology of ethnographic style questions, further questions were used to elicit more information (expansion) or for clarification purposes.

Member checking at descriptive (Seale, 1999) and analytical levels (Sobo, 2009) was carried out, and these checks allowed for further understanding to take place. Justification is given for choosing the focus group method for the analytical stage of member checking. The participants who were able to attend a focus group session were then separated into three groups. Participants were asked to evaluate whether the themes presented in a summary findings report reflected their own experiences. Finally, the process of the thematic analysis is outlined.

Findings

Participants' 'critical incident' (Fitzgerald, 2000) stories conveyed a sense of 'thick description' (Geertz, 1973) and are extensively drawn upon in the four findings chapters. The first findings chapter (Chapter 5) is about the reported difficulties that pre-registered mental health student nurses and their colleagues in clinical placement encountered when having to assess the clinical significance of religious phenomenology. Assessing the clinical significance of religious beliefs, experiences, and behaviours was seen by many of the participants as being particularly problematic. In a few cases, the student nurse participants mentioned that the

cultural validation of such phenomena made them question the clinical assessment that the service user lacked insight. These difficulties are related to Good and Good's (1986) concept of the 'normative uncertainty' evaluation dilemma, which is defined in the final background chapter (3).

The first findings chapter also examines some of the perceived reasons for these assessment and differential diagnosis (Dein, 2000) difficulties. In particular, there was a perception among some of the participants that pre-registered mental health student nurses lacked the culture specific knowledge to make informed assessments about the clinical significance of religious phenomenology. Formal education about the 'specific' beliefs and practices of religious groups and informational resources with culture specific content were recommended as ways of overcoming knowledge deficits. I then identify the problems involved in using culture specific knowledge to inform the assessment process, by drawing on the relevant academic literature.

Not only were participants able to identify the 'normative uncertainty' evaluation dilemma as an important issue in pre-registered mental health student nurses' clinical placements, but many of them could see its implications for clinical practice and their service users. These implications are the subject of the second findings chapter (6). In many cases, the 'normative uncertainty' evaluation dilemma resulted in clinical assessment errors (Minas, 1990; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Stolk, 2009). The misinterpretation of culturally validated phenomenology as psychopathological phenomena (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997) was the most commonly reported assessment error by the participants. These errors are linked to a 'culture blind' (Fernando, 2002; 2010) approach to clinical assessment and practice. The 'culture blind' approach was the consequence of poor standards of care, the professional culture of the placement setting, and the political economy of care. The decontextualisation of service users' experiences had negative impacts on the experiences of care and the appropriateness of psychiatric treatment given.

As the 'normative uncertainty' evaluation dilemma was the primary issue to emerge from the thematic analysis, it should not be surprising that the participants focused on how this issue was dealt with in clinical placement settings. Chapters 7 and 8

therefore, are more orientated to the second research question of this study. In chapter 7, I describe how mental health student nurses' drew on the assessment criterion of 'outcomes' (Jackson and Fulford, 1997) to inform their decision-making about the 'normative uncertainty' evaluation dilemma. The criterion of outcomes is defined at the beginning of chapter 7. More specifically, the participants' reports focused on three dimensions of the criterion of 'outcomes'-the 'impact on functioning', 'the assessment of risk', and the 'emotional valence' of the service user's experience. The academic literature is drawn on in discussing the utility of the criterion of outcomes in differentiating psychopathology from religious/culturally sanctioned experiences. Two other assessment strategies were raised by the participants and they are discussed in the latter sections of chapter 7. These two strategies were categorised in the thematic analysis as 'relying on intuition' and 'religious coping and psychopathology'.

Despite the constraints of the professional culture of the placement setting and the political economy of care more broadly, some of the participants mentioned that attempts were made to assess phenomena in their (perceived) cultural context. These assessment strategies and the issues which they raised for the participants is the focus of chapter 8. This chapter specifically looks at how some pre-registered mental health student nurses drew on their own stocks of cultural knowledge, and sought out the advice of culturally informed staff colleagues, (the service user's) family members, or religious group spokespersons when trying to distinguish psychopathology from culturally normative phenomena. The medical anthropological literature on 'cultural brokerage' (Weidman, 1982; 1983; Willigen, 2002; Lo, 2010), 'explanatory models' (Kleinman, Eisenberg and Good, 1978), and 'clinical recognition' (Carpenter-Song, 2011) provides the contextual backdrop for the discussion of these assessment strategies. Finally, in the conclusion, the key findings are summarised and the implications of the study for curriculum development and the clinical practice of pre-registered mental health student nurses are discussed. Recommendations for further research are also proposed in the study conclusion.

Summary

This introductory chapter gave an overview of the context, significance and structure of the study. The basic assumption of this research is that all pre-registered mental health student nurses' clinical interactions with service users in placement settings are 'multicultural' (Fitzgerald, 1992). I now turn to the first background chapter, which provides important details about the philosophical, theoretical and conceptual foundations of the study.

Chapter 1

Philosophical, Theoretical and Conceptual Foundations

Introduction

This background chapter sets out some of the main philosophical, theoretical and conceptual foundations of this research study. The cultural constructionist philosophical perspective (Gaines, 1991; 1992) and meaning centred theoretical paradigm (Good and Good, 1981; Gaines, 1982a; Good, 1994) that underpins this study is explained and justified. Culture is a key concept in this study; and therefore its various meanings and dimensions are outlined, and a 'mentalist' conceptualisation of culture is adopted (Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Williamson and Mullavey-O'Byrne, 1998). A distinction also is made between client attachment and location-based clinical placements (Callaghan, Cooper and Gray, 2007). Kleinman's (1978; 1980; 1984) 'health care systems' model provided the heuristic model for understanding pre-registered mental health student nurses' clinical encounters with service users. These encounters are conceptualised as 'multicultural clinical interactions' (Fitzgerald, 1992), as the provision of care to every service user, regardless of their ethnic identity, involves the interplay of multiple cultures (Hoeman, 1989; Hannah, 2011; Good, Hannah and Willen, 2011). The concept of multicultural clinical interactions is then discussed in the context of culture general competency (Fitzgerald, 2000).

All people exist in contexts of human relationships (Bonder, Martin and Miracle, 2002); and so the student nurse is almost never dealing just with the service user. Other people such as the service user's family members may be involved in care, help seeking, and decision making (Chrisman, 1977). Previous research has indicated the centrality of the family to the everyday discourse of health and social services professionals (Whybrow, Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Fitzgerald, et al., 1997a; Kilshaw, Ndegwa and Curran, 2002; Russell, et al., 2002; Fitzgerald, 2004; Seeley, 2006; Galanti, 2008). Thus, the cultural meaning of family will be addressed in this chapter. Pre-registered mental health student nurses also work in multidisciplinary mental health team settings (Bonham, 2004), and so many of their 'multicultural

clinical interactions' involve co-workers from different professional backgrounds. Values are discussed as an important dimension of culture (Winkelman, 1999; 2005); and in the health sciences (Anderson, 1985; 1987; 1990; Thorne, 1993; Seeley, 2004; 2005; 2006; Stolk, 2009) and medical anthropological literature (Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; Fitzgerald, et al., 1997a; Bonder, Martin and Miracle, 2001; 2002; 2004; Kilshaw, Ndegwa and Curran, 2002; Galanti, 2008), institutional, professional, and personal values are seen as exerting an important influence on health practitioners clinical interactions.

A Cultural Constructionist Philosophical Perspective

The purpose of this study was to understand the cultural issues and the responses to these issues as they emerged in pre-registered mental health student nurses' clinical placements. A cultural constructionist (Gaines, 1991; 1992) philosophical perspective was used to construct the meaning of these issues and responses from student nurses' and their nursing educators' perspectives. A cultural constructionist epistemology is subjectivist, as meaning is actively constructed and interpreted through an interactive process (Schwandt, 1994; 2000; Davies, 1999; Jenkins and Barrett, 2003). Allied to this epistemological perspective is the view that human behaviour is purposive, intentional, and directed towards goals (Mishler, 1981). Human practices are imbued with culturally based normative expectations that embody ideas about what one can reasonably expect in relation to other people's behaviour and actions (Koch, 1994; Bailey, 1997). The ontological position of cultural constructionism is relativistic, as social actors are seen to construct 'reality' in a myriad of different ways (Bailey, 1997; Crotty, 1998; Denzin and Lincoln, 2000). According to the nursing theorist Tina Koch (1999, p. 25), "'truth' is defined as the best informed and most sophisticated construction on which there is consensus". Thus, there can be no foundational basis for human experience or knowledge generation (Hollis, 1994; Willis, 2007).

In the cultural constructionist approach, the inter-subjective symbolic forms that mediate human experience and knowledge are both historically and culturally situated (Geertz, 1973; Good, 1994). Inter-subjective forms also are constructed through the medium of shared language, practices and understandings (Schwandt,

1994; 2000). It is these inter-subjective symbolic forms that are drawn upon by participants in 'multicultural clinical interactions' (Fitzgerald, 1992). Professional values, the organisational context of clinical placement, and student nurses' own personal orientations to culture informed the understanding of cultural issues and responses to these issues in clinical placement settings. Another defining feature of the cultural constructionist perspective (Gaines, 1991; 1992) is the attempt to gain meaning and understanding from situations and actions by interpretations and explanations of behaviours, rather than seeking cause and effect relationships (Mackenzie, 1994).

A Meaning-Centred Approach

This study adopted a meaning-centred medical anthropological theoretical approach (Good and Good, 1981; Good, 1994). Such an approach is appropriate, given its congruence with the cultural constructionist perspective (Gaines, 1991; 1992) of this study. Within the meaning-centred approach there are two underlying assumptions about the way meaning is created and presented (Good, 1994). Firstly, meaning is established as a network of symbols and language that provides the interpretive framework that is used to construct personal, social, and clinical realities (Good and Good, 1981). Secondly, networks of meanings are "the metaphors associated with disease, the ethnomedical theories, and the basic values and conceptual forms, and the care patterns that shape the experience of the illness and the social reactions of the sufferer in a given society" (Good and Good, 1981, p. 176). As Good and Good (1981) add, all illness episodes should be seen as fundamentally semantic (i.e., meaningful) and all clinical interactions should be seen as fundamentally hermeneutic. In a meaning-centred approach, the critical psychological mode of experiencing is 'verstehen' (to understand) rather than 'wissen' (to know), or 'erklaren' (to explain) (Gaines, 1982a).

The practitioner, service user, and any other participants involved in a 'multicultural clinical interaction' (Fitzgerald, 1992), should be seen as engaged in the interpretation of the context of the interaction (as symbolic itself) and of the symbolic forms manipulated by other participants in the interaction (Gaines, 1982a). In all 'multicultural clinical interactions' (Fitzgerald, 1992), meanings are brought to and

exchanged by participants through the employment of patterned and idiosyncratic symbolic forms (Good and Good, 1981). Symbols are seen as embodiments of meaning and are such things as words, acts, events, and gestures (Geertz, 1973). In this study I focus only upon student nurses' understandings, and nursing educators' interpretations of student nurses' understandings of service users' semantic illness realities (Good and Good, 1981). It was necessary to leave aside from consideration the fundamentally semantic nature of service users' illness episodes to focus fully upon the construction of 'clinical reality' (Kleinman, 1980) from student nurses' and their nursing educators' perspectives.

When student nurses' multicultural clinical interactions are considered as fundamentally hermeneutic (Good and Good, 1981), we are led to a focus on meaning and understanding. We need to consider the meanings of service users' presented illness beliefs and behaviours from the perspectives of student nurses. Student nurses are also involved in the active interpretation of other meaningful symbols that may manifest themselves in 'multicultural clinical interactions' (Fitzgerald, 1992). These meaningful symbols may relate to such things as physiognomy, the significance of service users' domains of discourse, styles of self-presentation, service users' insight into their mental illnesses, speech styles, and linguistic competence, gender, and a host of other characteristics.

The Meaning of 'Culture'

In the disciplinary field of anthropology entire books have been devoted to the meaning of culture (e.g., Kroeber and Kluckhohn, 1953). Despite its ubiquity in academic and popular discourses, anthropologists have been unable to agree on a single definition, which brings to mind Clifford Geertz's (1973) classic assertion that the concept of culture "obscures a good deal more than it reveals" (p. 4). Typically, anthropological definitions of culture have taken a 'materialist' (totalist) (Avruch and Black, 1991; 1993; Krefting, 1991b) or 'mentalist' perspective (Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Williamson and Mullavey-O'Byrne, 1998), although some scholars have tried to integrate the two perspectives (Hahn, 1995; Ember, Ember and Peregrine, 2002). The two perspectives often are distinguished by their understandings of how culture functions (Vivelo, 1978; Armstrong and

Fitzgerald, 1996). The materialist perspective deals with the 'products of culture'- the observed 'patterns of behaviour' and the possessions and symbols of a particular group (Keesing and Keesing, 1971; Fitzgerald, 1991). In contrast, in the mentalist approach, culture is perceived as a "shared system of rules or a pattern for behaviour" (Keesing and Keesing, 1971, p. 20), and a "conceptual code" (Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997, p. 18) that people use to "order their perceptions and experiences and make decisions, and in terms of which they act" (Vivelo, 1978, p. 17). Culture as conceptualised in the mentalist perspective is closely associated with the concept of 'consciousness' and addresses "assumptions and presuppositions that individuals and groups hold about the world" (Avruch and Black, 1991, p. 27-28).

Another widely accepted approach to unpacking the meaning of culture has been to set out its agreed dimensions (Haviland, 1997; Keesing and Strathern, 1998; Yule, 2008). A careful study of these dimensions helps in understanding the influence and function of culture in pre-registered mental health student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992). The majority of anthropologists would accept that culture is learned (Levine, 1987; Ember and Ember, 1988; 1992; Lynch and Hanson, 1992; Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995). In other words, humans are not born with a particular cultural genetic blueprint; rather, culture is learnt through the processes of socialisation and enculturation (Goodenough, 1981; Litterst, 1985). 'Enculturation' refers to the acquisition of cultural knowledge that allows an individual to function effectively as a member of society (Chrisman and Johnson, 1996). The primary means of cultural transmission occurs through the processes of observation, social interaction and discourse (Bonder, Martin and Miracle, 2004).

Culture also is considered to be a set of shared patterns of perceiving, adapting, interacting, and behaving towards others and the environment (Domini-Lenhoff and Hedrick, 2000; Stewart, 2002). The sharing of culture leads to expectations and enables one to predict how others are likely to behave in a given situation or interaction (Ajjawi and Rees, 2008). Culture is not a 'one size fits all concept' (Harris, 2004), as although culture is both learned and shared, it is not replicated in the same way in each individual person. Each person possesses an individual variation that

has been influenced by his or her personal attributes and experiences (Kennedy, 1997; Dreher and MacNaughton, 2002; Leavitt, 2002). It also is said that culture encompasses a person's beliefs, values and norms (Armstrong and Fitzgerald, 1996; Purnell and Paulanka, 1998; Winkelman, 1999; 2005).

Values refer to learned beliefs that relate to a person's preference for particular ways of behaving and 'end states of being' (Rokeach, 1973). Rokeach (1979, p. 2) defined the cultural dimension of values as "core conceptions of the desirable within every individual and society" and as standards that steer not only behaviour, but also "judgement, choice, attitude, evaluation, argument, exhortation, rationalization and one might add attribution of causality". Values therefore, convey a cognitive and emotional load (Fitzgerald, et al., 1996) and their violation usually generates emotionally charged responses (Sanchez, 1964; Williams, 1968; Porter and Samovar, 1994). They can be stated overtly or be inferred from non-verbal behaviour (Robinson, 1998), and are affected by the stage of the life course (Winkelman, 1999; 2005). Values are reflective of a cultural pattern or system and are intertwined with worldviews and standards of morality (Winkelman, 1999; 2005). However, they are also idiosyncratic, as intracultural variations in the pattern of values are exhibited and people continually reconsider these patterns for their degree of personal relevance (Bonder, Miracle and Martin, 2002). Religious teachings are a cultural embodiment of values and can have important influences upon behaviour by providing ultimate justifications and prescriptions about one's relationship to nature and other people (Winkelman, 1999; 2005; Fernando, 2002; 2010). Outside the context of religion, one's culturally informed values are based in and reinforced by one or more social institutions (e.g., economic, political and family structures) (Bonder, Martin and Miracle, 2001; 2002; 2004). When describing the influence of values, it is preferable to talk about value orientations rather than discrete sets of values (Bonder, Miracle and Martin, 2001; 2002; 2004).

In clinical placement, a pre-registered mental health student nurse works "in a social, political, and physical context, all of which are influenced by culture" (Fitzgerald, et al., 1997a, p. 17); and that itself "exist within a web of assumptions, expectations, and evaluations that reflect the competing influences of employees, employee groups, clients, managers, owners, regulators, and various related institutions"

(Bonder, Martin and Miracle, 2002, p. 112). Thus, student nurses are always working in placement settings that are defined by organisational and professional cultures (Good, 1995a; b; Galanti, 2008). These organisational and professional cultures are underpinned by certain notions of the 'self' (Seeley, 2006), which may sometimes be in direct conflict with the values of student nurses and/or service users. Mattingly and Fleming (1994) used the term 'underground practice' to describe how health care professionals adhere to organisational dicta while at the same time finding ways to meet service users' needs that do not conform to those dicta. In the context of this background chapter, what is particularly important to note is that the organisational and professional values of the mental health setting interact with the values of health care practitioners and help to determine service users' and/or their family network's experiences of health care (Anderson, 1985).

Finally, it is acknowledged that culture is not static, but is dynamic, fluid, hybrid, and ever changing (Culley, 1996; 2000; 2001; 2006; Culley and Demaine, 2006). According to Kirmayer (2012, p. 155), "culture involves a flexible, on-going process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between ethnocultural communities and institutions of the larger society, like the health care system, as well as global networks". In cultural environments of hyper-diversity (Hannah, 2011), clinical interactions represent multiple forms of identity and difference "in which the link between racial-ethnic identity and culture is weak or broken (shattered) and, as a result, in which broad, identity based indicators of cultural difference prove too blunt an instrument for navigating the social heterogeneity within today's clinical environment" (Good, Hannah and Willen, 2011, p. 20-21).

The conceptualisation of culture used in this study needed to be congruent with the cultural constructionist perspective (Gaines, 1991; 1992) of this research project. Sandy Lovering's (2008) adaptation of Spradley (1979), Helman (2007), and Fitzgerald, Mullavey-O'Byrne and Clemson's (1997) definitions of culture was used. Lovering (2008, p. 15) defined culture as "the learned and shared values, beliefs and meanings that forms the lens or perspective through, which an individual understands and interprets his or her experiences". The concept of culture is integral to this study for a number of related reasons, all of which will be covered in the

background chapters. In sum, for a 'meaning centred' medical anthropology (Good and Good, 1981), culture defines 'clinical reality', 'abnormality', and the origins and mechanisms ('explanatory models') of illness (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980).

Clinical Placement

According to Callaghan, Cooper and Gray (2007, p. 18), the purpose of clinical placement "is to give students exposure to a range of clinical environments that will enable them to develop a broad range of clinical competencies that they can use as a qualified mental health nurse". Typically, half of a student's training takes place within the clinical environment (English National Board for Nursing, Midwifery and Health Visiting and Department of Health, 2001). While there are several models of clinical placements, client attachment and location-based placements represent the two most common types (Callaghan, Cooper and Gray, 2007). In a location-based placement, the student nurse is assigned to a specific area of clinical practice for a specified amount of time, and for its duration is supervised by an assessor or mentor (English National Board for Nursing, Midwifery and Health Visiting and Department of Health, 2001). The conventional wisdom is that the location-based placement will help the student to develop the competencies and skills to deliver the type of nursing care that service users need (Callaghan, Cooper and Gray, 2007). At the beginning of the placement, the student is provided with a list of the skills and learning outcomes that they are required to achieve by its completion. Callaghan, Cooper and Gray listed the advantages of location-based placements as including the following: Providing student nurses with a base for clinical learning and good sources of learning; giving students the opportunity to apply the skills they have learned formally in class; providing students with the opportunity to demonstrate their competencies under the guidance of supervision; and to introduce students to the reality of nursing practice. The disadvantages of this form of placement were outlined by Callaghan, Cooper and Gray as involving the following: Lack of available mentors and assessors; lack of staff; placements being unable to cope with the number and demand of student nurses; and students not getting the opportunity to work with service users' long term. They also note that their effectiveness in actually providing

students with the necessary skills and competencies is largely anecdotal and the duration of placements does not fit in with stated learning needs.

The client attachment approach to clinical placement is a more recent development in the clinical education of pre-registered mental health student nurses (Jackson and Pogson, 1995). According to Jackson and Pogson, the purpose of the client attachment approach is to enable students to develop clinical experience by forming long-term attachments with individual service users. Rather than being placed on a succession of location-based placements, students demonstrate their clinical capabilities by working with a caseload of service users in a range of practice settings and with a variety of clinical presentations (Callaghan, Cooper and Gray, 2007). With the exception of Turner, Callaghan, Eales and Park's (2004) study at City University in London, the evidence for the effectiveness of this model also is largely anecdotal.

The student nurses who were involved in this PhD research had to undergo two twelve week blocks of clinical placement in academic years two and three. Furthermore, each block of clinical placement was preceded by a 12 week block of formal education and theory in a University setting. Although the type of clinical settings that the students experienced were varied, the aim was that students should have at least one in-patient clinical placement, two placements in community settings, and one specialist type placement. The placement experience itself may involve the student working in a crisis team, rehabilitation setting, forensic setting (e.g., prison), children's mental health services (CAMHS), services dealing with drug and alcohol issues, and acute or older people's inpatient wards.

'Multicultural Clinical Interactions': The Intersection of 'Popular', 'Folk' and 'Professional' Health Care System Sectors

Kleinman's (1978; 1980; 1984) 'health care systems model' that conceptualises the three sectors in which illness is interpreted, experienced, and reacted to provided the heuristic model for understanding the meaning of cultural issues that arose from pre-registered mental health student nurses' clinical placements. Health care systems are distinct cultural systems (Littlewood, 1989; Hahn, 1995) and are socially organised responses to illness that integrate the three health sectors of a society

(Kleinman, 1978; 1980; 1984). Each of these three sectors includes distinct beliefs about illness and healing, defined roles and interactions between healers and patients, and settings or institutions where the healing takes place (Kleinman, 1980). Kleinman (1978) defined these three overlapping and interconnected domains as the 'popular', 'folk', and 'professional' sectors.

Kleinman (1980) conceptualised the 'popular' sector as the lay, non-specialist arena (usually involving the family), where health is maintained and the majority of illness is recognised and treated. It is estimated that between 70 to 90 per cent of healthcare takes place in the 'popular' domain (Kleinman, Eisenberg and Good, 1978). In the popular sector, the health beliefs and cultural values held by the person and their family influence the help seeking process (Chrisman, 1977). Another sector is concerned with the 'folk' or non-professional healers, and is based around sacred and secular perspectives (Kleinman, 1978; 1980; 1984). According to Helman (2000; 2007), 'folk' healers share the basic cultural values, health beliefs and worldviews of their community. Finally, the 'professional sector' comprises the legally sanctioned healing professions (Kleinman, 1978). In the UK, certified medical doctors of various types and specialities and paramedical workers-nurses, midwives, physiotherapists, occupational therapists, and other support workers (i.e., health care assistants) make up the legally legitimated healing professions (Chrisman, 1986; Helman, 2000; 2007). These healing professions apply a biomedical or allopathic perspective to explain, manage, and treat illness (Kleinman, 1978; 1980; 1984). This cultural belief system of biomedicine is elevated above all other forms of health care in the UK (Helman, 2000; 2007). Within the professional sector, mental health nursing exists as its own subculture with its specialised language, knowledge base, practices, and 'normative behaviours' (Anderson, 1985; 1987; 1990).

'Explanatory models' (EM) (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980), the subject of the next background chapter, derive from these interconnected, but distinct sectors. Kleinman (1978; 1980; 1984) and later, Fitzgerald (1992), argued that service user-health care practitioner clinical interactions constitute transactions between explanatory models. The 'explanatory model' concept (Kleinman, 1980) refers to the cultural notions about a specific episode of illness and its treatment. They are held both by healers and lay people (Kleinman, Eisenberg and Good,

1978). In the meaning centred paradigm (Good and Good, 1981; Gaines, 1982a; Good, 1994), healing is understood as a transaction process that involves 'popular', 'folk' and 'professional' belief systems or sectors (Kleinman, 1978; 1980; 1984). 'Professional', 'popular' and 'folk' models of illness are held concurrently in all cultures (Helman, 2000; 2007). In any clinical interaction, the mental health student nurse and the service user move in and out of these three sectors and thus their explanatory models of distress can be influenced by any or all of them (Kleinman, Eisenberg and Good, 1978; Fitzgerald, 1992; Helman, 2000; 2007). In some circumstances, the explanatory model of a student nurse may be incompatible with the explanatory models of the mental health professionals that they work with.

While mental health practitioners work primarily with biomedically based explanatory models that are derived from the 'professional' sector, service users' explanatory models tend to draw on the 'popular' and 'folk' sectors of the healthcare system (Kleinman, 1978; 1980; 1984). However, Fitzgerald and colleagues' (1997a) note that practitioners and service users may draw on "knowledge, beliefs, values, and practices from multiple domains" (p. 85) as the popular and folk sectors can interconnect with the professional (biomedical) sector (Helman, 2000; 2007). Therefore beliefs derived from the 'popular' and 'folk' sectors may be incorporated into a practitioner's clinical practice (Kleinman, 1980). In many cases, this incorporation is implicit and there is an unawareness of competing or incompatible value systems (Fitzgerald, 1992; Fitzgerald, et al., 1997a). As the nursing theorist Thorne (1993, p. 1936) noted: "It seems evident that we Westerners, like the members of all human cultures, are capable of simultaneously holding mutually exclusive and logically incompatible beliefs about health and illness". There is a potential for this incompatibility to be heightened for the nurse when there are greater differences between their own personal health beliefs and healing traditions, on the one hand, and the values of the biomedically informed 'professional' (Kleinman, 1978; 1980; 1984) medical system (Fitzgerald, 1992; Andrews and Boyle, 2003), on the other. This may lead to "an incompatibility between these worldviews and potential for conflict" (Lovering, 2008, p. 176). In a case detailed by Herberg (1995), a general adult nurse giving care to a patient who was contemplating an abortion is then asked to give the patient health advice that conflicted with their religious beliefs and values. The nurse may ask to be assigned to another patient or

makes the decision that the patient's right to the health information outweighs their own personal considerations. In either case, the nurse chooses between conflicting norms and values. Thus, the acculturation process of becoming a health professional can be a stressful process that may involve conflicted loyalties between different value positions that may not always be reconciled (Fitzgerald, 1992).

In many cases, the self-reported clinical interactions in this PhD research went beyond a dyadic encounter between a pre-registered mental health student nurse and a service user. Service users are people who exist in the context of human relationships (Fitzgerald, Mullavey-O'Byrne and Clemson, 2001; Bonder, Martin and Miracle, 2002; Russell, et al., 2002; Fitzgerald, 2004; Galanti, 2008; Sobo and Loustaunau, 2010). A health practitioner's clinical interaction may involve other people connected to the service user's care, help seeking and decision making processes (Fitzgerald, 2004). The service user's caretakers, close friends, and family members may become involved in discussions around the practitioner's recommendations and treatments (Bonder, Martin and Miracle, 2002). Considerable pressure may be imposed on the service user and/or the practitioner to align with one or another of these conflicting agendas (Fitzgerald, 2004). Pre-registered mental health student nurses' clinical placements take place in multidisciplinary team mental health settings (Bonham, 2004), and many of the reported clinical interactions in this research involved co-workers from different professional backgrounds. All of these individuals have their own vantage points and explanatory models (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980), and agendas.

When Kleinman's (1978; 1980; 1984) health care systems model is applied to pre-registered mental health student nurses' clinical interactions, at least three cultural systems are involved (Fitzgerald, 1992). These three cultural systems were defined by Fitzgerald (1992) as (a) the personal or familial culture of the health practitioner, which is primarily influenced by the 'popular' and 'folk' sectors; (b) the culture of the service user, which is primarily influenced by the 'popular' and 'folk' sectors; and (c) the culture of the primary medical system, which is primarily influenced by the 'professional' sector of biomedicine. Each of these cultural systems is associated with its characteristic explanatory models. So we can see that in any clinical interaction, one or more medical systems are involved, and the participants enter the

interaction with “multiple cultural lenses” (Fitzgerald, et al., 1997a, p. 19). According to Fitzgerald (1992) the participants in a clinical interaction “may, or may not, share knowledge of all the systems involved” (p. 3). The greater the shared knowledge, the less likely that there will be misunderstandings, “but when participants have little knowledge of the other cultures or systems involved, some problems are almost assured” (Fitzgerald, 1992, p. 2). As all clinical interactions involve the multiple interplay of cultures, medical systems, and frames of reference (Tebutt and Wade, 1985; Hoeman, 1989), pre-registered mental health student nurses’ clinical encounters can be defined as ‘multicultural clinical interactions’ (Fitzgerald, 1992).

‘Multicultural Clinical Interactions’ and ‘Culture General Competency’

Clinical anthropology has faced a battle in its attempts to persuade the health professions “that cultural data and a culturally sensitive approach are relevant to all patients, not just to those whose ethnic background happens to be different from the practitioners” (Chrisman and Johnson, 1996, p. 101). The aforementioned concept of ‘multicultural clinical interactions’ (Fitzgerald, 1992) is concerned with ‘culture general competency’ (Cope, et al., 1997) and the idea that the “principles, knowledge, skills, etc. associated with intercultural competency¹ are treated as applicable to all interactions, whether or not there are obvious cultural differences” (Fitzgerald, 2000, p. 187). It therefore diverges from the ‘othering’ tendency of traditional cultural competency (Fitzgerald, 2000; Canales and Bowers, 2001). According to Fitzgerald (2000, p. 187), culture general competency is “about the ability to function in the ambiguous, dynamic, open-ended interactions common to therapy situations for which no adequate cultural blueprint exists; and do so with a reasonable level of comfort”. The culturally general competent practitioner is able to interpret these interactions as “‘cultural scenes’ (Spradley and McCurdy, 1972) or ‘social dramas’ (Turner, 1974) and to do so from multiple perspectives” (Fitzgerald,

¹ According to Fitzgerald (2000), ‘intercultural competency’ developed with the growing awareness that practitioners had to be sensitive to the needs of people from cultures that were distinctively different from their own. Much of the health sciences literature has advocated this form of cultural competency (Kim, 1991; Lustig and Koester, 1996). The focus of intercultural competency has been on practitioners working across cultures (Fitzgerald, 2000). It is different, therefore, to ‘culture general competency’ (Cope, et al., 1997) that views all clinical interactions as multicultural (Fitzgerald, 1992). Willen, Bullon and Mary-Jo Delvecchio Good (2010), and Seth Donal Hannah (2011) also remind us that is untenable to presume a dichotomy between ‘mainstream practitioner’ and ‘other’ service user, as in many cases, these roles are reversed.

2000, p. 187-188). This approach attempts to achieve something in line with Clifford Geertz's (1973) idea of 'thick description' and an understanding of the potential implications of culture (as a general concept) for the content and context of everyone's illness and clinical experiences at the micro and macro level (Fitzgerald, 2000). This understanding is used as a basis for clinical action (Fitzgerald, 2000).

The culture general competency approach does not assume that the practitioner must simulate another cultural identity (Fitzgerald, 1996) and thus, there is recognition "that culture influences everyone's perceptions, interpretations and evaluations of the situation" (Fitzgerald, 2000, p. 188). If the practitioner is aware of the multiple cultural influences on a clinical interaction, misunderstandings or 'disconfirmed expectancies' usually can be avoided (Fitzgerald, 1992; Mullavey-O'Byrne, 1994a; b; 1999; Mullavey-O'Byrne and Fitzgerald, 1995; Fitzgerald, Robison, Clemson and Mullavey-O'Byrne, 1997; Mullavey-O'Byrne and West, 2001). The practitioner applies flexible and adaptive strategies, which allows them to effectively respond to the issues presented in a 'multicultural clinical interaction' (Fitzgerald, 1992) and therefore, "act in an informed, culturally and psychologically sensitive, appropriate, non-judgemental, meaningful way" (Fitzgerald, 2000, p. 188). Fitzgerald's (2000) 'culture general competency' approach also is reflected in Roland Littlewood's (1998) argument that the 'new perspective of cross-cultural psychiatry' is relevant to understanding the meaning of emotional experience in all situations and not just among cultural and ethnic minorities. A premise of this PhD study was based on Lambert and Sevak (1996) and Carpenter-Song, Nordquest Schwallie and Longhofer's (2007) assertion of the need to move beyond the study of ethnic differentials between health practitioners and service users in clinical interactions, by exploring (from the perspectives of pre-registered mental health student nurses and nursing educators) the rift between professional and lay understandings of health and illness and the clinical encounter.

The 'Family' and 'Multicultural Clinical Interactions'

No matter how they are conceptualised or organised, the family is an intrinsic feature of the cultural and social fabric of society. As Fitzgerald (2004, p. 489) suggests, the family is a "cultural universal and a cultural icon". The family provides a key context for socialisation by helping to forge a person's identity and by moulding that person's

behaviour in relation to others (Ember and Ember, 1992; Gropper, 1996; Ravertz, 1998; Winkelman, 1999; 2005; Fitzgerald, 2004; Giger and Davidhizar, 2004; Galanti, 2008). It is the context in which the beliefs, values, attitudes, and customs that guide much of everyday life are learnt and reinforced (Bonder, Martin and Miracle, 2001; 2002; 2004). Even if a person's family is not physically or emotionally accessible, it may still exert an important influence on their life (Fitzgerald, 2004).

Despite its universality, "much ink has been used up, in anthropology and comparative sociology, trying to define 'the family'" (Keesing and Strathern, 1998, p. 233). Thus, there is no great surprise that practitioners find the concept of family seemingly simple, yet difficult to understand and deal with during their 'multicultural clinical interactions' (Fitzgerald, 1992; 2004). One standard anthropological definition of the family is that it can be understood as "a social and economic unit consisting minimally of one or more parents and their children" (Ember and Ember, 1988, p. 329). According to Fitzgerald (2004), such a simple definition, however, belies the complexities of family configurations and reconfigurations that emerge over time and in relation to things like marriage, births, deaths, divorces, migration, illnesses, and other relevant factors. Although some ideal family configuration may be identified at a given place and point in time, in any given society there is a great deal of diversity in family structure, role, and responsibilities (Sparling, 1991; Hartley, 1995; Ingoldsby and Smith, 1995; Gropper, 1996; Winkelman, 1999; 2005; Galanti, 2008). Patterns of parenting, marriage, kin relationships, and responsibilities vary across and within cultures, as does the nature of family life, childrearing, and care of the aged (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997). Responsibilities and roles within families also are structured by age and gender (Fitzgerald, 2004).

This diversity in family form, role, and responsibility is readily apparent in multicultural societies where there is immigration and internal migration (Fitzgerald, 2004). Family relationships are most often based on 'blood' and genealogical ties, but other criteria can be used to determine family membership, both in the long term and for special situations (e.g., god parents) (Winkelman, 1999; 2005). A member of a family based on 'fictive' kin ties may acquire similar rights and responsibilities to a member of a family that is organised around blood and genealogical ties (Fitzgerald,

2004). All these factors illustrate that the concept of family is a cultural construction or 'cultural unit' (Sparling, 1991) that is constantly redefined and reconfigured. In addition, even within a distinct cultural group, each family unit must be considered as unique (Storer, 1985; Sparling, 1991; Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997).

Fitzgerald and colleagues' (1997a) note that the literature on the cultural construction of the family has tended to suggest that it plays a more involved and critical role in the lives of its members in non-western societies. Often this literature dichotomises the family form by using terms such as 'idiocentric' (self-centred) versus 'sociocentric' (social group centred), or 'individualist' versus 'collectivist' (Hofstede, 1980; Mullavey-O'Byrne, 1994a; Brislin and Yoshida, 1994; Berry, Poortinga, Breugelmans and Chasiotis, 2011). However, some academics have pointed out that such broad conceptual distinctions need to be treated with caution (Fitzgerald, et al., 1997a; Seeley, 2006).

As the family forms a central feature of most people's lives, pre-registered mental health student nurses often interact with service users' families during clinical placement (Bonham, 2004). The clinical anthropological (Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Fitzgerald, et al., 1997a; Fitzgerald, 2004; Bonder, Martin and Miracle, 2001; 2002; Galanti, 2008), transcultural nursing (Murphy and Clark, 1993; Kim, 1998; Spence, 1999; Boi, 2000; Gerrish, 2000; 2001; Ozolins and Hjelm, 2003; Cortis, 2004; Cioffi, 2005; 2006; Hultsjo and Hjelm, 2005; Lundberg, Backstrom and Widen, 2005; Vydelingum, 2006; Berlin, Johansson and Tornkvist, 2006; Severinsson, 2008; Berlin, 2010), and related health sciences literature (Phipps, 1995; Fadiman, 1997; Yang, Shek, Tsunaka and Lim, 2006), has suggested that families are part of the everyday discourse of health care practitioners. This discourse about families is cultural discourse, as it "is grounded in cultural ideas and ideals about families" (Fitzgerald, 2004, p. 489). Much of the transcultural and anthropological nursing literature (Gardenswartz and Rowe, 1998; Luckmann, 1999; Giger and Davidhizar, 2004; Boyle, 2008; Galanti, 2005; 2008; Holland and Hogg, 2010) also has encouraged nurses to understand the role that the family can play in a service user's life and to involve families in the care of service users. For a variety of reasons, it also is clear that when mental illness is involved,

the family may play a somewhat different role than if the family member is suffering from a physical illness (Fitzgerald, et al., 1997a).

Summary

This chapter has outlined the philosophical, theoretical and conceptual context of this study. A meaning-centred (Good and Good, 1981; Gaines, 1982a; Good, 1994) medical anthropological paradigm was chosen, because of its compatibility with the cultural constructionist philosophical approach of this study (Gaines, 1991; 1992). The structure and types of clinical placement were described and pre-registered mental health student nurses' clinical encounters with service users and/or other participants such as the service user's family members were conceptualised as 'multicultural clinical interactions' (Fitzgerald, 1992). 'Multicultural clinical interactions' are embedded in the health care system and draw on aspects of its three sectors (Kleinman, 1978; 1980; 1984). The service user's family is central to the everyday discourse of health care professionals (Whybrow, Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Fitzgerald, et al., 1997a; Kilshaw, Ndegwa and Curran, 2002; Russell, et al., 2002; Fitzgerald, 2004; Seeley, 2006; Galanti, 2008); and therefore the cultural meaning of family (Sparling, 1991) was addressed in this background chapter.

The concept of culture used in this study is firmly located in the 'mentalist' perspective (Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Williamson and Mullavey-O'Byrne, 1998) and was then linked to the concept of culture general competency (Fitzgerald, 2000). The central concept of culture is key to understanding institutional, professional and a student nurses' personal values (Bonder, Martin and Miracle, 2002), 'clinical realities' (Kleinman, Eisenberg and Good, 1978), notions of the 'self' (White and Marsella, 1982; Seeley, 2006), family (Fitzgerald, 2004), definitions of 'abnormality' (Good and Good, 1986), and 'explanatory models' (Kleinman, 1980). The next chapter conceptualises pre-registered mental health student nurses' 'multicultural clinical interactions' as the transaction of explanatory models (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980). These explanatory models are situated in the 'clinical realities' of 'disease'

and 'illness' (Eisenberg, 1977), cultural notions of the 'self' (White and Marsella, 1982; Seeley, 2006), and the problematic clinical concept of 'insight' (Jacob, 2010).

Chapter 2

'Disease'-'Illness' Perspectives, 'Explanatory Model' (EM) Transactions, Conceptions of 'Self', and 'Multicultural Clinical Interactions'

Introduction

Applying a culturally informed and 'meaning centred' (Good and Good, 1981; Gaines, 1982a; 1991; 1992; Good, 1994) medical anthropological perspective enables one to explore the illness beliefs and behaviours that are brought by participants to 'multicultural clinical interactions' (Fitzgerald, 1992). The 'explanatory model' concept (EM), which was originally developed by Arthur Kleinman (1980), is one such culturally informed and meaning centred medical anthropological concept. Kleinman's (1980) explanatory model concept concretises the important anthropological distinction between 'disease' and 'illness' (Eisenberg, 1977) and the related 'emic'-'etic' perspectives (Skultans and Cox, 2000). The anthropological distinction between 'disease' and 'illness' is based on a perspectivist view, in that distress may be understood in different ways, depending on whether the phenomenon is approached from the vantage point of the 'professional' (etic) perspective (sector) of 'disease' or the 'popular' and 'folk' (emic) (sectors) conceptions of 'illness' (Kleinman, 1978; 1980; 1984).

The explanatory model concept (Kleinman, 1980) refers to the cultural notions about a specific episode of illness and its treatment, which is held by all those engaged in the clinical process. While explanatory models must always be seen in context, as they are applied in response to a specific episode of illness, they also draw on particular cultural belief systems or 'cultural theories of illness' that a person or a group of people hold about a given set of symptoms or illnesses (Good and Good, 1981; Landy, 1983; Parry, 1984; Meadows, 1991; Mattingly and Beer, 1993; Hudelson, 1994; Moss-Morris and Petrie, 1994; Helman, 2000; 2007; Winkelman, 2009). These cultural theories or belief systems may locate the cause of a person's illness within the individual, natural, social, supernatural or moral domain (Landy, 1983; Helman, 2000; 2007; Lipsedge, 2007), and these domains have been associated with either 'personalistic' or 'impersonalistic' casual assumptions

(Eisenbruch, 1990). A person's illness may be constructed as having proximal and ultimate causes and, thus, more than one cultural theory of illness can be involved at the same time (Helman, 2000; 2007).

Kleinman's (1980) explanatory model concept is critical to understanding the assumptions and expectations (Mullavey-O'Byrne and Fitzgerald, 1995) that health practitioners, such as pre-registered mental health student nurses bring to their 'multicultural clinical interactions' (Fitzgerald, 1992). The incompatibility of a service user's and/or their family's explanatory models with the models held by a mental health practitioner is often the basis for 'disconfirmed expectancies' (Mullavey-O'Byrne and Fitzgerald, 1995) and 'critical incident' narratives (Laws and Fitzgerald, 1997; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; Fitzgerald, et al., 1997a). 'Multicultural clinical interactions' (Fitzgerald, 1992) in the 'professional' sector (Kleinman, 1978; 1980; 1984) of mental health care have been conceptualised as the transaction of service users' and/or family members' and mental health practitioners' explanatory models (Kleinman, 1980).

The explanatory model construct (Kleinman, 1980) also is related to the problematic clinical concept of 'insight' (Johnson and Orrell, 1995; McGorry and McConville, 1999; Saravanan, et al., 2004; Jacob, 2010). Indeed, it has been argued that an alternative explanation for the label of 'low insight' is the incongruence of a service user's explanatory model for their distress with that of the explanatory model of the mental health practitioner and primary medical system (McGorry and McConville, 1999). However, the mainstream psychiatric literature (e.g., Endicott, et al., 1982; Wilson, Ban and Guys, 1986; Kay, Fisbein and Opler, 1987) has focused almost exclusively on the psychological and neurological basis of insight; and in mental health nursing, the dominant concern has been with treatment compliance (Pinkihana, Happell, Taylor and Keks, 2002; Coombs, Deane, Lambert and Griffiths, 2003). Thus, the social and cultural aspects of insight, including the role of explanatory models have been downplayed (Kilshaw, Ndegwa and Curran, 2002).

Through its conceptions of 'self' (Geertz, 1973; 1983), I will discuss how medical anthropology can enhance the understanding of pre-registered mental health student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992). Specific notions of the self not only underlie explanatory models of distress (Kleinman, 1980), but all

aspects of clinical practice and care (Seeley, 2006). Although the mental health nursing profession can be seen as an occupational culture with its own particular systems of thought, worldviews, explanations, beliefs, norms, rules, and values (Holden and Littlewood, 1991; Andrews and Boyle, 2003; Lovering, 2008; Galanti, 2008; Berlin, 2010), wider cultural views of 'self' (Seeley, 2006) are built into the frameworks of nursing training, assessment, and treatment approaches.

'Etic' and 'Emic' Perspectives

The debate about 'etic' versus 'emic' meanings (Skultans and Cox, 2000), which has underpinned much work in medical anthropology, including the 'disease' and 'illness' perspective distinction (Eisenberg, 1977), the related 'explanatory model' (EM) (Kleinman, 1980) concept, the notion of 'category fallacy' (Kleinman, 1977; 1988a), and the 'rationality' and 'relativism' debate (Hollis and Lukes, 1982), has been shaped by the historical legacy of its parent discipline of socio-cultural anthropology. The 'etic' and 'emic' concepts are derivatives of the linguistic terms 'phonetic' and 'phonemic' (Pike, 1966). While the term 'phonetic' refers to patterns of sound sequences and relationships of contiguity-where things are placed in relation to each other, the term 'phonemic' is concerned with relations of semantic or meaning similarity (Skultans and Cox, 2000). The distinction between 'etic' and 'emic' meanings can be elaborated respectively in terms of 'form' and 'content' (Littlewood, 2000), and in terms of imposed meanings and subjective internal meanings (Skultans and Cox, 2000). Medical anthropologists (e.g., Swartz, 1998; Galanti, 2008) have recommended that mental health practitioners integrate both perspectives to provide a more complete and holistic picture of a person's distress.

The Anthropological Distinction between 'Disease' and 'Illness'

Medical anthropologists (e.g., Hahn, 1995; Winkelman, 2009) have used the umbrella term 'malady' to encompass the array of concerns about compromised well-being. The maladies of 'disease' and 'illness' normally are considered as synonyms; however, medical anthropologists have made an important conceptual distinction between the two terms (e.g., Fox, 1968; Fabrega, 1972; Eisenberg, 1977; Cassell, 1978; Kleinman, Eisenberg and Good, 1978; Kleinman, 1980; Helman, 1981; 2000; 2007; Hahn, 1995). The anthropological distinction between 'disease'

and 'illness' is based on the view that the same phenomenon (distress) may be understood in different ways, depending on whether the phenomenon is approached from the 'clinical reality' of the 'professional' (etic) perspective (sector) of 'disease', or the 'popular' and 'folk' (emic) (sectors) conceptions of 'illness' (Kleinman, 1978; 1980; 1984; Harwood, 1981; Pool and Geissler, 2005).

This distinction is important to bear in mind, because as Bhui and Bhugra (2002) explain; a service user's perception of their symptoms may well be markedly different from a mental health practitioner's conceptualisation of the service user's symptoms. The 'disease' vs. 'illness' conceptual distinction is embedded within a relativist and meaning-centred theoretical framework (Good and Good, 1981), and furthermore, is crucial for the medical anthropologist who is trying to demonstrate how the elicitation of the service user's perspective is critical to the delivery of culturally sensitive care (Chrisman and Johnson, 1996).

There is agreement among medical anthropologists (e.g., Eisenberg, 1977; Kleinman, Eisenberg and Good, 1978; Good and Good, 1981; Hahn, 1995) that the concept of 'disease' refers to the pathological processes of body or mind that are confirmed by scientific and biological methods (Chrisman, 1986; 1991; Pilowsky, 1997). Diagnostic tools and laboratory tests are required to achieve this 'objective' understanding, and ill health tends to be reductively defined as a deviation from biologic norms (Krefting and Krefting, 1990). These biologically caused mental disorders are assumed to have a universal aetiological basis and discrete and recognisable symptoms regardless of the culture in which they are manifested (White and Marsella, 1982). In psychiatric diagnosis, overt signs and symptoms are assumed to be direct manifestations of an underlying pathology, which is most likely located in an individual's brain (White, 1982b).

Some specialisms within the 'professional' sector of biomedicine (Kleinman, 1978; 1980; 1984), such as psychiatry, mental health nursing, and occupational therapy, also do work with psychological, behavioural, and social models of mental illness (Winkelman, 2009). However, the biomedical model still is dominant and is embodied in both the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM) (American Psychiatric Association, 1987; 1994) and the 'International Classification of Mental and Behavioural Disorders' (ICD) (World Health Organization, 1992). Thus,

from the biomedical perspective of 'disease', biology is assumed to be more basic and significant than psychological, cultural, social, or moral issues in the aetiology and manifestation of distress (Krefting and Krefting, 1990; Littlewood, 2000).

Kleinman (1980) has criticised the biomedical perspective of 'disease' for denying the person's experience of 'illness', by its exclusive focus on the presumed underlying pathology. How a person understands their illness experience is primarily of relevance to the clinical task of formulating a diagnosis, which according to Pilowsky (1997, p. 21), is a "pattern recognition' exercise involving comparison of symptoms with classical patterns", which have been developed within a materialist framework (Grof, 1985). A psychiatric diagnosis is however not based on direct observation, but is an interpretation (using cultural categories [of the DSM and ICD]) of a patient's interpretation (using their personal and cultural categories) (Kleinman, 1996).

The patient presents more than with a disease, in that they present with an "illness experience, which provides a context of meaning to the disease" (Andary, Stolk and Kilmidis, 2003, p. 86). There have been different views put forward in the medical anthropology literature about the meaning of the concept of 'illness' (Kleinman, 1980; Good and Good, 1981; Hahn, 1995; Fabrega, 1997). The majority view however, is that the concept of 'illness' refers to devalued changes in being, as experienced, described, and explained by the sufferer of distress (Chrisman, 1986; Hahn, 1995). According to Helman (1981, p. 548), 'illness' is the "subjective response of the patient to being unwell: how he (or she), and those around him (or her), perceive the origin and significance of this event; how it effects his (or her) behaviour or relationships with other people; and the steps he (or her) takes to remedy the situation". Thus, it is the phenomenon on which people base their 'help seeking behaviour' and resort to treatment (Chrisman, 1977).

The concept of 'illness' encompasses personal, interpersonal, and cultural reactions to distress (Krefting and Krefting, 1990). Lewis-Fernandez and Kleinman (1995) noted that 'illness' is as much a cultural category as language. While both language and illness are deeply influenced by biologic parameters, they also are constructed in diverse ways by local social formations (Kilshaw, Ndegwa and Curran, 2002). In addition to the changes we may experience in the interior of our bodies, what we

experience as undesirable or as 'illness' may come from many sources and conceptual frameworks (Foster and Anderson, 1978; Helman, 2000; 2007). The concept of illness involves meanings that have deep affective roots in a person's lifestyle, including the social relationships through which these meanings are communicated (Chrisman, 1991). A person's illness behaviour also is a normative experience, as "'approved' ways of being ill" are both learnt and shared (Kleinman, Eisenberg and Good, 1978, p. 252).

At the same time, the perspectives of 'disease' and 'illness' are not separate entities, but rather are 'explanatory models' (EM) (Kleinman, 1980), which to some extent, overlap. The 'explanatory model' (EM) concept (Kleinman, 1980) aids in concretizing the 'disease' and 'illness' distinction and the related 'etic'-'emic' perspectives (Chrisman and Johnson, 1996; Chrisman and Zimmer, 2000; Skultans and Cox, 2000). As Eisenberg (1977) explained, such models are ways of constructing 'clinical reality' and imposing meaning on the chaos of the phenomenological world. They mirror multilevel relations between separate aspects of a complex, fluid, and total phenomenon called 'sickness' (Hahn, 1995; Winkelman, 2009).

Conceptions of the 'Self' and their Relevancy to Understanding Pre-Registered Mental Health Student Nurses' 'Multicultural Clinical Interactions'

It is through its conceptions of 'self' and 'personhood' as mediated by culture, and therefore, as relative within and across cultural contexts, that medical anthropology can enrich the understanding of pre-registered mental health student nurses' 'multicultural clinical interactions' (Seeley, 2004; 2005; 2006). Although notions of 'person' and 'self' often are used interchangeably, some clarification is necessary. More specifically; "the notion of self-entails reflexivity and an opposition of 'self' and 'other' which 'person' does not" (White and Marsella, 1982, p. 21).

Cultural anthropologists (e.g., Geertz, 1973; 1983; Heelas and Lock, 1981; Gaines, 1982b; Gaines and Hahn, 1982; Shweder and Bourne, 1982; 1984; White and Kirkpatrick, 1985) have posited that the 'Western' tendency to view the 'self' as located inside an individual body, that is, invariant across contexts, introspective, and capable of change, and as a "bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement, and

action that is organized into a distinctive whole” (Geertz, 1983, p. 59), is a sociocultural construction, rather than a biological given or genetic imperative. In the words of the Indian psychoanalyst Sudhir Kakar (1990, p. 443); “cultural ideas...pervade the innermost experience of the self. One cannot therefore speak of an ‘earlier’ or ‘deeper’ layer of the self beyond cultural reach”. These anthropological perspectives also have criticised psychological conceptualisations of the ‘self’, for restricting the understanding of cultural influences on the ‘self’ to superficial overt behaviours, and as something as distinct from a person’s basic feelings and conflicts (Seeley, 2006).

Nucci (1997) has referred to such anthropological theorists as ‘cultural constructivists’. As cultural constructivists, “embrace a psychological relativism in which personhood and the individual are cultural variants rather than expressions of some underlying set of psychological realities” (Nucci, 1997, p. 6). Thus, from the standpoint of ‘cultural constructionism’, understanding of oneself does not grow from an ‘inner’ essence, which is relatively independent of the social world, “but from experience in a world of meanings, images and social bonds” (Rosaldo, 1984, p. 139). Rather, than being enduring, bounded inner entities, selves are a creation of acting and understanding that is derived from culture (Kilshaw, Ndegwa and Curran, 2002).

In this cultural constructionist understanding of self, modes of relationship-both “with other persons and with the natural and supernatural worlds-vary greatly from culture to culture” (Seeley, 2006, p. 76), and the self’s experience of time, space, relationship, identity, as well as its ways of constructing meaning is highly variable cross-culturally. By their suggestion, that every historical era and cultural context creates specific and distinctive configurations of the self, cultural constructionist viewpoints, provide perspectives that are largely absent from clinical theory (Seeley, 2006).

Explanatory models (EM) of illness (Kleinman, 1980), the subject matter of the next section in this background chapter, lie at the intersection of culturally mediated conceptions of self (Kilshaw, Ndegwa and Curran, 2002) and ‘cultural theories of illness’ (Helman, 2000; 2007), both of which are likely to be universal aspects of cultural knowledge (White and Marsella, 1982). As Kilshaw, Ndegwa and Curran

(2002, p. 16) explained; “the notion of boundaries, ascribed identity, notions of self and the interface between these levels of experiences are commonly present in cases of mental illness”. Thus, in the context of ‘multicultural clinical interactions’ (Fitzgerald, 1992), mental health practitioners encounter distressed service users whose issues lie in ‘identity’ and ‘self’. Pre-registered mental health student nurses and other practitioners who work with distressed service users, must make a special effort to understand the ways in which these distressed states are understood, experienced, and interpreted by service users in their care (Kilshaw, Ndegwa and Curran, 2002).

From the ‘professional’ sector (Kleinman, 1978; 1980; 1984) of a biomedically dominated mental health care sector, the causation of psychopathology is characteristically located within the individual, as in its constitution, history, and personality (White and Marsella, 1982; Littlewood, 1990; Seeley, 2006; Marsella and Yamada, 2007). This is then the appropriate focus for psychiatric intervention. The criteria for mental health in the ICD (World Health Organization, 1992) and the DSM (American Psychiatric Association, 1987; 1994), assume that the person should have a stable and individualist sense of self that is defined as being separate and independent from others (Andary, Stolk and Klimidis, 2003). As Mercer (1986) and Littlewood and Lipsedge (1997) have argued, this emphasis on the individual has meant that questions of intergroup relations and economic power is reinterpreted through a focus on the individual as victim.

Such a cultural conception of psychological illness can be distinguished from many non-Western and minority cultures where either supra-individual powers or social relationships are commonly perceived as causative factors for distress or misfortune (White and Marsella, 1982; Marsella and Yamada, 2007). For example, anthropologists (e.g., White, 1982a; b; Shweder, 1991) have drawn attention to how the community (especially the family) rather than the physical body is the essential unit for conceptualising distress in certain cultural contexts. Not only “is the family the locus for what we might term ‘psychopathology’, but physical symptoms too can be understood only through the individual’s relationships with others” (Littlewood, 1990, p. 316). That is, a disturbed body reflects disharmony in the social order and appropriate interventions are more somatic and moral rather than psychological.

These cultural understandings are distinct from the old western assumption that non-Western societies have undifferentiated selves. Rather, the notion of self may be differentiated according to quite different criteria, which frequently are 'moral' rather than 'psychological' (Harre, 1986; Littlewood, 1990).

Mental health nursing and other professions in the biomedical dominated 'professional' sector (Kleinman, 1978; 1980; 1984) of mental health care, not only embody 'Western' notions of the self in their view of 'psychopathology', but also actively promote them in their everyday practice and care (Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Bonder, Martin and Miracle, 2001; 2002; 2004; Seeley, 2006). When mental health practitioners encourage their service users to function autonomously, to separate from their parents, to become more assertive and expressive, or to pursue their self-interests, they are encouraging them to enact Western ideals of 'selfhood' (Seeley, 2006). A person who does not desire autonomy, rejects personal responsibility, and who is seen as being 'dependent' on a group, is likely to be perceived by a mental health professional as being psychologically immature and inadequate (Andary, Stolk and Kilmidis, 2003). Indeed, medical anthropologists and some theorists in the health sciences have argued that values such as autonomy, independence, and privacy are reflective of a 'highly individuated' notion of 'self' (Gaines, 1982b; Gaines and Hahn, 1982; Dyck, 1989; 1991; 1998; Krefting, 1991b; Holden and Littlewood, 1991; Kinebanian and Stomph, 1992; Herberg, 1995; Paul, 1995; Whiteford, 1995; Hocking and Whiteford, 1995; Gerrish, 2000; Whiteford and Wilcock, 2000; Robinson and Gilmartin, 2002; Whiteford and Wright St-Clair, 2002; Andrews and Boyle, 2003; Awaad, 2003; Hanssen, 2004; Bourke-Taylor and Hudson, 2005; Galanti, 2008; Lovering, 2008; Berlin, 2010; Sobo and Loustaunau, 2010).

These are values that have been shown to prevail in Western health care settings (Whybrow, Fitzgerald and Mullavey-O'Byrne, 1996; Russell, et al., 2002; Fitzgerald, 2004) and in the practice of nursing (Gerrish, 2000; Galanti, 2005; 2008). Thus, implicit in this cultural construction of the self is a culturally based conception of 'normality' and 'abnormality', a specific view of how emotions should be expressed, regulated, interpreted, and experienced, and a specific view of how a person should relate to others (Andary, Stolk and Kilmidis, 2003). As Kilshaw, Ndegwa and Curran

(2002) note, a mental health worker “who assumes a certain notion of self, of boundaries and of ascribed identity will often fail when confronted with a patient who does not share his or her beliefs” (p. 16).

Cultural constructionist conceptions of the self are, however, sometimes flawed by an inattention to intragroup and interpersonal differences (Seeley, 2006). At the same time, anthropological perspectives about cross-cultural variations in the self are helpful to student nurses and other mental health practitioners working with service users from different cultures, as they portray the vast range of possible human selves encountered in ‘multicultural clinical interactions’ (Fitzgerald, 1992).

‘Multicultural Clinical Interactions’ as ‘Explanatory Model’ (EM) Transactions

Introduction

Different approaches have been proposed by medical anthropologists and health scientists to make sense of the beliefs and behaviours associated with the aforementioned concepts of ‘disease’ and ‘illness’ (Eisenberg, 1977). Of particular note for this background discussion is the ‘health beliefs model’ (Beck, 1974; McSweeney, Allen and Mayo, 1997; Mikhail and Petro-Nustas, 2001) and the ‘explanatory model’ (EM) (Kleinman, 1977; 1978; 1980; 1988a; b; Kleinman, Eisenberg and Good, 1978; Kleinman and Benson, 2006). The health beliefs model is underpinned by a positivist epistemology, which is reflected in its central assumption that people make rational choices and decisions about the prevention and treatment of disease (Good, 1994).

From the perspective of meaning centred medical anthropology (Good and Good, 1981; Gaines, 1982a; 1991; 1992; Good, 1994), the health beliefs model can be criticised for being too health provider focused, and more importantly for failing to acknowledge the influence of culture on health beliefs and help seeking behaviour. The positivist approach underpinning the health beliefs model is incompatible with the cultural constructionist and meaning-centred theoretical basis of this research study.

The explanatory model (EM) is based on a culturally situated meaning or view of illness (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980), and is different, therefore, in fundamental ways from the positivist-orientated health beliefs model. In particular, the explanatory model (Kleinman, Eisenberg and Good, 1978; Kleinman, 1980) concept is based on a meaning-centred (Good and Good, 1981; Gaines, 1982a; 1991; 1992; Good, 1994) and cultural relativist approach (Swartz, 1998) to understanding beliefs about distress, help seeking (Chrisman, 1977) and illness behaviour. On this basis the explanatory model is congruent with the cultural constructionist stance of this study.

The explanatory model concept also is integral to this study for three further reasons. The first reason follows on from one of the underlying premises of this study, which is that rather than examining specific cultural differentials about distress, a more useful approach is to explore (from the perspectives of mental health student nurses and their nursing educators) the rift between biomedical and lay understandings of distress (Lambert and Sevak, 1996; Carpenter-Song, Nordquest Schwallie and Longhofer, 2007).

Secondly, the explanatory model concept has framed the cultural critique of the clinical concept of 'insight' (McGorry and McConville, 1999; Saravanan, et al., 2004; Jacob, 2010), a subject which is discussed in a later section of this background chapter. While there is broad agreement in the mainstream psychiatric literature that loss of awareness of deficits and denial of illness are largely a direct product of whatever disease process underlies mental illness, the alternative argument is that the assessment of 'insight' is shorthand for the compatibility of a service user's explanatory model and conditions of treatment with that of a mental health practitioner's explanatory model and treatment of psychopathology (Perkins and Moodley, 1993; Johnson and Orrell, 1995; 1996; Beck-Sander, 1998; Kilshaw, Ndegwa and Curran, 2002; Saravanan, et al., 2004; Jacob, 2010).

Thirdly, the explanatory model concept overlaps with the theme of the next background chapter-the 'normative uncertainty' (Good and Good, 1986) evaluation dilemma, and clinical judgements about 'normality' and 'psychopathology'. Diagnostic errors or errors in the assessment process may occur if a service user holds an explanatory model that is incompatible with the assumptions of the mental

health practitioner's explanatory model (Kleinman, 1980; Eisenbruch, 1990; Kirmayer, Young and Robbins, 1994; Sang, 1996; Lefley, Sandoval and Charles, 1998; Andary, Stolk and Klimidis, 2003).

It is important to bear in mind that when reviewing studies that have used explanatory models to explore mental health professionals' clinical interactions, that these studies will inevitably reflect their specific cultural context and the concerns of the health care providers working in them. Furthermore, during the search of the literature, I could not find any empirical studies which have examined the influence or role of explanatory models on pre-registered or registered mental health nurses' 'multicultural clinical interactions' (Fitzgerald, 1992).

The Meaning of the 'Explanatory Model' (EM) Concept

In his seminal book 'Patients and Healers in the Context of Culture', Arthur Kleinman (1980), a renowned psychiatrist and medical anthropologist, defined the 'explanatory model'² (EM) as "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process, whether patient or clinician" (p. 105). Kleinman (1980, p. 105) goes on to outline five major issues which explanatory models seek to answer in relation to a specific episode of illness: (1) aetiology or causation; (2) time and mode of the onset of symptoms; (3) pathophysiology; (4) course of the illness (which includes the appropriate illness behaviour and perceived level of severity of the disorder); and (5) appropriate treatment response.

These five notions or components of an explanatory model (Kleinman, 1980) are responsive to fundamental questions concerning the 'why', 'what', and 'how' of Illness (Fitzgerald, 1992; Weiss and Somma, 2007). The explanatory models held by mental health practitioners tend to address most or all of these five factors. In contrast, service users' and their family members' explanatory models deal with what are perceived as the most pressing and salient issues at the time (Kleinman, 1980). For example, a few anthropological studies have shown how some lay explanatory

² Other terminology used in the research literature for the concept of 'explanatory model', has included: 'illness model' (Turk, Rudy and Salovey, 1986), 'illness representation' (Leventhal, Meyer and Nerenz, 1980), or 'illness schema' (Angel and Thoits, 1987). For sake of consistency and for its original definition, the term 'explanatory model' (Kleinman, 1980) is used in this thesis.

models mainly emphasise the causes and consequences of an illness, with very little attention given to pathological mechanisms (White, 1982b). Explanatory models also influence many aspects of illness behaviour such as help seeking, treatment compliance, patient satisfaction, and coping (Andary, Stolk and Klimidis, 2003). That is, they not only “disclose the significance of a given health problem for patient and family” (Kleinman, 1980, p. 106), but, “they guide choices among available treatments” (Andary, Stolk and Klimidis, 2003, p. 85).

The initial idea behind the explanatory model concept was to draw on social anthropological understandings of subjective experiences of distress and to apply them directly to psychiatric practice (Dein, 1997; 2003; Bhui and Bhugra, 2002; 2004). According to Weiss and Somma (2007, p. 131), the explanatory model framework “provided a means of bridging cultural differences between patients and clinicians with different backgrounds in multicultural practice settings and they also provided a means of bridging conceptual differences and promoting empathy and a therapeutic alliance, even when patients and clinicians came from similar cultural backgrounds”. So one of the reasons why Kleinman’s work has been so important to the field of clinical practice is the emphasis on the need for health practitioners and service users to negotiate their ‘clinical realities’ or social constructions of the illness experience.

In general, however, explanatory models are not shared or negotiated in ‘multicultural clinical interactions’ (Fitzgerald, 1992), as they often “conflict and have negative therapeutic consequences” (Kilshaw, Ndegwa and Curran, 2002, p. 29). The mental health practitioner’s explanatory model may be so different from the service user’s and/or their family’s explanatory model that they may well misinterpret it. Writing in the context of clinical psychiatry, Kleinman has suggested (1980) that the mental health practitioner will almost certainly “fail to treat problems that are part of the patient’s EM, but not the medical EM” (p. 116). The likely outcome is that the service user and/or their family will reject or fail to comply with the treatment recommended by the health practitioner. Indeed, Callan and Littlewood (1998) demonstrated how service user satisfaction in relation to their treatment by mental health professionals is associated with shared and negotiated explanatory models.

In a research sense, the appeal of the explanatory model concept has been in its application to the examination of 'multicultural clinical interactions' (Fitzgerald, 1992) and the consequences resulting from the incompatibility between service users' and health practitioners' explanatory models of illness (Laws and Fitzgerald, 1997; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; Fitzgerald, et al., 1997a; Kilshaw, Ndegwa and Curran, 2002; Shapiro, Hollingshead and Morrison, 2002; Kai, et al., 2007; Pieper and MacFarlane, 2011). Krefting and Krefting (1990) in particular, have noted how health care professionals in the primary medical system and lay people may "differ greatly in their understandings of a particular illness episode and especially in etiology, labelling or diagnosis, and treatment" (p. 115).

It is overly simplistic to construct 'multicultural clinical interactions' (Fitzgerald, 1992) as a transaction between the explanatory models of a service user and a mental health practitioner. As in certain incidences, a mental health practitioner may need to negotiate with the explanatory models of a service user's family members or between the explanatory models of a service user and their family members (Chrisman, 1991; Chrisman and Zimmer, 2000). A service user may sometimes be even caught in the middle between a practitioner and their family's explanatory models for their distress (Fitzgerald, et al., 1997a).

Fitzgerald and colleagues' (1997a) research on 'multicultural clinical interactions' from the perspectives of occupational therapists working in mental health settings in Sydney, Australia, illustrated the differences that may occur between a service user's family's explanatory models and the 'biopsychosocial' explanatory model for mental illness. This issue, which often was a source of confusion and conflict for the occupational therapists in their self-reported 'multicultural clinical interactions', was related to explanatory model differences about the cause, nature, progress, and prognosis of the service user's distress. A service user's family's belief that demons or other kinds of supernatural entities was the ultimate cause of their relative's distress, which the occupational therapists' 'biopsychosocial' model ascribed to mental illness, emerged in several of the 'critical incident' narratives collected during the research.

Fitzgerald et al.(1997a) also found that even if a service user unconditionally accepted an occupational therapist's 'biopsychosocial' explanatory model for their

illness, there was still scope for the explanatory model of that service user's family support network to be at odds with the explanatory model of the occupational therapist. This finding was supported by Chrisman and Zimmerman (2000), who suggested that the explanatory models of a service user and their family members may diverge considerably. As Fitzgerald and colleagues' (1997a) pointed out, it is often difficult for mental health practitioners to realise that a family member's explanatory model may be one of many that a distressed service user holds in mind. Thus, there is a need for practitioners to appreciate that a service user and their family members may not share the same explanatory models.

Another important and aforementioned influence on the development of the explanatory model framework has been the contribution of the so called 'etic'-'emic' paradigm (Skultans and Cox, 2000) and the anthropological distinction between 'disease' and 'illness' (Eisenberg, 1977). The perspectivist view provided by the 'etic'-'emic' paradigm and the anthropological distinction between 'disease' and 'illness' was brought directly into mental health practitioners' clinical practice and training with the emergence of the explanatory model concept (Katon and Kleinman, 1981; Littlewood, 1990). In particular, the task of eliciting service users' explanatory models shares a common interest in elaborating 'emic' accounts of illness (Weiss, 1997; Kleinman and Benson, 2006). That is, while there is a need for mental health practitioners to explain their cultural beliefs and values and how they view distress, there also is a need to understand these things from the service user's and their social network's perspective (Kleinman, Eisenberg and Good, 1978). According to Kleinman and Benson (2006, p. 1674), "explanatory models ought to open clinicians to human communication and set their expert knowledge alongside (not over and above) the patient's own explanation and view point". There is a need to understand not just the service user's perspective (explanatory model), but also the service user's perception of the mental health practitioner's perspective (explanatory model).

Explanatory models are embedded in larger cognitive systems that are derived from and constructed by cultural and social structural arrangements (Kleinman, 1980). Both service users' and health practitioners' explanatory models share a common body of meanings with members of their subcultural group that in turn is influenced by the wider contextual web of shared meanings, which Good and Good (1981) have

referred to as 'semantic illness networks'. Some of the initial formulations of the explanatory model concept in the ethnomedical literature dealt insufficiently with how explanatory models are elicited and modified within the context and processes of social interactions (Dein, 2003). However, as explanatory models are culturally based, they are therefore, dynamic and susceptible to change (Kleinman, 1980). Explanatory models are not hermeneutically sealed, but are actively constructed and negotiated with the explanatory models of other participants and the wider social environment (Katon and Kleinman, 1981). They may also change when the situation does not meet the expectations of a person's model (Fitzgerald, et al., 1997a). Although explanatory models are embedded in culture and society, they may also take on unique forms within specific families and individuals (Fitzgerald, 1992).

'Cultural Theories of Illness' and 'Explanatory Models'

While explanatory models must always be seen in context, as they are employed in response to a given episode of illness (Kleinman, 1980), they also draw on particular cultural belief systems that a person or a group of people hold about the cause of a set of symptoms or illnesses (Good and Good, 1981; Landy, 1983; Parry, 1984; Meadows, 1991; Mattingly and Beer, 1993; Hudelson, 1994; Moss-Morris and Petrie, 1994; Helman, 2000; 2007; Lipsedge, 2007; Winkelman, 2009). These 'cultural theories of illness causation' typically derive from the 'individual'³, 'natural'⁴, 'social'⁵, 'supernatural'⁶, or 'moral'⁷ domain (Landy, 1983; Helman, 2000; 2007; Lipsedge, 2007). Furthermore, an episode of illness may be regarded as having 'proximal' and 'ultimate' causes (Helman, 2000; 2007), and these causes may derive from different

³ According to Helman (2000; 2007), lay theories of illness causation ascribe the origin of a person's illness within the individual body, and thus, the responsibility for the illness falls primarily on the 'sick' person themselves. A person's illness may therefore, be evidence of their carelessness, and they "should feel guilty for causing it" (Helman, 2007, p. 135).

⁴ The natural domain of illness causation is concerned with the living and inanimate natural environment (i.e., climatic conditions, influence of planetary bodies, injuries, infestation by parasites, infections, or influence of environmental irritants) (Helman, 2000; 2007).

⁵ The social domain focuses on the interpersonal level for the causation of illness (i.e., illness is a result of witchcraft, sorcery, or the evil eye), where other people are blamed for one becoming ill (Helman, 2000; 2007).

⁶ Theories of illness causation that are concerned with the supernatural world ascribe illness to the external agency of supernatural entities, such as gods, spirits, or ancestral shades (Landy, 1983; Helman, 2000; 2007).

⁷ Illness may be linked to transgressions of a moral nature. Moral theories are invariably fused with supernatural theories of illness causation, as illness may be perceived as a divine form of punishment for breaching a religious taboo or violation of a behavioural norm (Shweder, 1991; Lipsedge, 2007).

domains or cultural theories of illness causation (i.e., 'individual', 'natural', 'social', 'supernatural', or 'moral domain').

So it is important to recognise that 'individual', 'natural', 'social', 'supernatural' and 'moral' cultural theories of illness causation are not necessarily mutually exclusive or incompatible (Helman, 2000; 2007). Indeed, these aetiological factors may be linked together (multicausal) (Helman, 2000; 2007) in a particular episode of illness (Lloyd, et al., 1998; McCabe and Priebe, 2004). For example, 'supernatural' theories of illness causation tend to involve 'personalistic' assumptions (Eisenbruch, 1990), meaning that an external (supernatural) personal agent acted intentionally to cause the illness, due to some moral transgression on the part of the sufferer of the illness (Shweder, 1991).

Snow's (1983) study of health beliefs is instructive in this regard, as it illustrated how supernatural and moral theories of illness causation could become fused among their sample of low-income African Americans. The African Americans in Snow's study explained the cause of illness as being a 'reminder' from God for some behavioural lapse, such as neglecting to go to church regularly, not saying one's prayers, or not thanking God for daily blessings. Illness was thus perceived as a 'whuppin', a divine punishment for sinful behaviour, 'moral error', and not thinking or acting in a spiritual enough way. From the perspective of Snow's African American cohort, seeking help from the biomedical and 'professional' (Kleinman, 1978; 1980; 1984) sector of the health care system was not considered appropriate for the treatment of illness. A 'cure' for these African Americans, rather, involved the acknowledgment of sin, sorrow for having committed it, and a vow to improve one's future behaviour. Prayer and repentance for one's sin cured illness.

Viewing suffering as a distinctive morally and/or supernaturally influenced form of distress raises the fundamental question of bafflement—"why me" (Kleinman, 1988b, p. 29)? Although we may accept that illness is part of nature and that it happens through a predictable series of circumstances, or by accident or bad luck, the search for meaning still may remain strong (Dein and Lipsedge, 1998). Elworthy (1989) and Fitzgerald (1992) have suggested that during our life course we are faced with a whole world of phenomena that baffles understanding, and therefore, we search for meaning in an attempt to comprehend it. Explanatory models as expressions of

belief systems and cultural theories of illness (Helman, 2000; 2007) may be viewed as a way of attaching meaning to the suffering that illness causes (Gil, 1998). In this light, we can see how supernatural forces are often invoked to make sense “of things that have no meaning, like incomprehensible ills, adversity, and death, which strike haphazardly and inexplicably return” (Gil, 1998, p. 18). According to Dein and Lipsedge (1998), all religions and all belief systems “provide a vocabulary of suffering” (p. 145) and this may be personal, communal, or universal.

By contrast, biomedical or what Eisenbruch (1990) has termed as ‘impersonalistic’ explanations for illness tend to absolve the sufferer of primary responsibility for their illness and “thus, anyone, even ‘good people’ (including therapists) can have a mental illness” (Fitzgerald, et al., 1997a, p. 86). In a strict sense, biomedical aetiologies of illness remove the primary grounds upon which ‘stigma’ may be based (Swartz, 1998). As stigma is associated with social disgrace and being deemed ‘bad’ by society, and it usually implies that a person or their socially significant others are engaged in some form of socially disapproved behaviour (Fitzgerald, et al., 1997a). While moral problems and/or supernatural causes of illness may be a pressing concern for a service user and their family, these concerns are not considered within the biomedical framework of the DSM (American Psychiatric Association, 1994) and the ICD (World Health Organization, 1992), other than as indicators of psychopathology (Kirmayer, Young and Robbins, 1994; Pilowsky, 1997; Swartz, 1998).

The extent to which biomedical explanatory models of ‘illness’ do in fact avoid moral judgements has been hotly debated by medical anthropologists (e.g., Lock and Gordon, 1988). Some medical anthropologists (e.g., Kleinman, 1988b; 1992; Kleinman and Kleinman, 1991) have even argued that all explanations of illness embody a moral message. As Weitz (1991, p. 35) explained; “social constructions of all illnesses develop through subjective, moral judgements that declare ill persons less socially worthy than healthy persons and somehow responsible for their illnesses”. At the most basic level, to define something as a disease or illness is to deem it undesirable (Conrad and Schneider, 1980). That is-to make a moral judgement about its meaning and value.

The Meaning of Lay and Practitioner ‘Explanatory Models’

Lay explanatory models are said not to possess single referents, but instead, are seen to represent semantic networks that loosely link a variety of concepts and experiences (Good, 1977; Lloyd, et al., 1998). Kleinman has (1980) suggested that “vagueness, multiplicity of meanings, frequent change, and lack of sharp boundaries between ideas and experiences are characteristic of lay explanatory models” (p. 107). In most cultures, lay explanatory models are part of the complex body of inherited folklore, which in industrialised countries is increasingly influenced by the mass media and the biomedical model of ‘disease’ (Eisenberg, 1977; Tseng and McDermott, 1981; Tseng and Streltzer, 2008). They may be part of wider concepts about the origins of misfortune in general (‘cultural theories’ and illness ‘domains’) (Landy, 1983; Helman, 2000; 2007; Lipsedge, 2007). Moreover, it should be noted that these lay explanatory models may refer to specific conditions, or are used generally and without differentiation (Tseng, 2001). Ethnicity, socio-economic status, and education influence the choice of metaphor and ‘idiom’ for the expression of distress (Nichter, 1981).

In Kleinman’s (1980) initial definition of the concept, the idioms, metaphors, and logics of lay explanatory models are substantially different to the explanatory models applied by mental health practitioners. According to Kleinman (1980), health practitioners’ explanatory models tend to rely on “single casual trains of scientific logic” (p. 107). Atwood Gaines (1982b) and Maureen Fitzgerald’s (Fitzgerald, 1992; 2004; Fitzgerald and Mullavey-O’Byrne, 1994; 1995; Fitzgerald, Mullavey-O’Byrne and Clemson, 1997; Fitzgerald, et al., 1997a) respective anthropological research on psychiatrists and occupational therapists has demonstrated how health practitioners’ explanatory models are invariably based on the cultural assumptions of biomedicine and influenced by practitioners’ professional socialisation and subsequent clinical interactions. In the context of nursing, Ketefian and Redman have written (1997, p. 15) that “a western perspective generally pervades organising concepts and frameworks in nursing and thus, is a dominating influence in knowledge development and research”. However, Kleinman (1980) argued that if the explanatory models employed by practitioners are to be practically effective, they usually must “diverge considerably from biomedical and other professional theories” (p. 108).

Other medical anthropologists (e.g., Gaines, 1982c; Stein, 1990; Fitzgerald, et al., 1997a; Joel, et al., 2003) have suggested that practitioners' explanatory models draw on all sectors of the healthcare system. Both Fitzgerald and colleagues' (1997a) 'critical incident' focused research on the 'multicultural clinical interactions' of Australian based occupational therapists and Joel and colleagues' (2003) study with mental health case workers in India found that mental health practitioners' may hold coexisting and not necessarily congruent explanatory models. These explanatory models not only drew from the 'professional' sector of biomedicine (Kleinman, 1978; 1980; 1984), but also from 'popular' and 'folk' sectors of the healthcare system. At the same time, as Ketefian and Redman (1997) noted, the dominative influence on nurses' and other mental health practitioners' explanatory models, tends to be the biomedical model of 'disease' (Eisenberg, 1977). As Patel and colleagues' (1995) argued, while an individual practitioner may strive admirably to understand the contribution of their service user's culture to the conversation created between them in the clinical process, they will rarely give the same scrutiny to the role of their own culturally determined belief system.

In a focused ethnographic study, which explored the clinical interactions between mental health professionals and Afro-Caribbean service users in London (Kilshaw, Ndegwa and Curran, 2002); it was found that practitioners' gave little consideration to understanding service users' and/or their family members' explanatory models. In particular, the studied clinical interactions seemed to take on the form of practitioners trying to convince and educate service users of the health professional's biomedical explanatory model for their distress. However, these biomedical explanatory models did not seem to have any meaning for service users and/or their family members, and even if they did have any meaning, the meaning was entirely negative.

Similarly, studies examining clinical interactions from the perspectives of Australian based mental health occupational therapists (Fitzgerald, et al., 1997a), British based medical students (Kai, Bridgewater and Spencer, 2001), Swiss junior doctors in general practice (Hudelson, 2005; 2006), Canadian paediatric residents (Lingard, Tallett and Rosenfield, 2002), emergency care nurses working in Sweden (Ozolins and Hjelm, 2003), and general nurses working in a medical directorate in the south of England (Vydelingum, 2006) have all found that while health practitioners referred

to the culturally influenced illness beliefs of their service users, they did not view themselves as holding cultural beliefs about illness. The health practitioners in these studies portrayed themselves as the bearers of 'fact', while service users and their family members were presented as the bearers of culture and belief. As Fitzgerald and colleagues' (1997a) explained; there was the explicit assumption that the explanatory model which informs the 'professional' (sector) perspectives of health practitioners was the correct model, rather than an alternative interpretation of a service user's distress.

Drawing on the work of the sociocultural anthropologist Sharon Traweek⁸ (1988), the medical anthropologist Janelle Taylor (2003a; b; 2010) has persuasively argued that health practitioners working within the primary sector of biomedical health care operate in what she defined as a "culture of no culture" (2003b, p. 556)-that is "a community defined by the shared cultural conviction that its shared convictions were not in the least cultural, but rather, timeless truths" (Taylor, 2003b, p. 556). Within this 'culture of no culture', biomedical knowledge is understood not to be "merely 'cultural knowledge', but *real* knowledge" (Taylor, 2003b, p. 556).

Much of the work carried out by medical anthropologists (e.g., Chrisman and Maretzki, 1982; Clark, 1983; Good, 1995a;b; Santiago-Irizarry, 1996; 2001; Hunt, 2001; 2005; Good, James, Good and Becker, 2002; Fox, 2005; Hunt and DeVoogd, 2005; Borovoy and Hine, 2008; Brown and Barrett, 2010) has questioned "the

⁸ Sharon Traweek's (1988) ethnographic study of high-energy physicists working at the Stanford Linear Accelerator sought to contextualise this community's systems of thought in relation to their systems of social action. Thus, Traweek sought to situate the science of high energy physics in relation to the patterned ways that this community of physicists organised themselves socially. Traweek also was interested in how this community reproduced itself and how it produced new generation of physicists who would take their places within its social and professional hierarchies, while at the same time, assuming the community's values, assumptions, and goals as their own. In particular, Traweek (1988, p. 14) states: "I believe that to understand how scientific and technological knowledge is produced we must understand what is uncontested as well as what is contested, how the ground state is constructed as well as how the signals called data are produced. When I speak of the shared ground I do not mean some a priori norms or values but the daily production and reproduction of what is to be shared...the forces of stability, the varieties of tradition, in a community dedicated to innovation and discovery". As Janelle Taylor (2003b) explained in her article for *The Journal of Academic Medicine*; what emerges from Traweek's (1988) study is how the world of high energy physics could be depicted as a 'culture of no culture'-that is, a community defined by the shared cultural belief that its convictions shared among its community members were not in the least cultural, but were rather timeless truths.

As Taylor (2003b) goes on to argue; while clinicians differ from physicists in many aspects, what underpins a clinician's training is the confidence in the truth of biomedical knowledge to alleviate suffering. From such a perspective, biomedical knowledge, like the knowledge generated by high energy physicists, may be perceived as a 'culture of no culture'.

privileged status” (Lock and Gordon, 1988, p. 7) and ethnocentrism (Sobo and Loustaunau, 2010) associated with the biomedical model which has dominated the provision of mainstream mental health services in the UK and other Western societies. For medical anthropologists, and the ‘new cross cultural psychiatry’ framework, biomedicine like other healing traditions is an ‘ethnomedical’ system (Hahn and Kleinman, 1983)-that is, a cultural construction with its own sets of beliefs, assumptions, values, behaviours, biases, and sub-specialisms (like psychiatry and mental health nursing).

In addition, the health practitioner’s grounds for negotiation with the explanatory models of the service user and/or their family members can be influenced by factors such as socio-economic status, ethnicity, gender, and age (Parsons, 1990). A Swedish qualitative study (Wachtler, Brorsson and Troein, 2006) of general practitioners’ consultations with immigrant patients reinforced such a view, as practitioners’ willingness to engage with patients’ explanatory models were associated with such variables as educational level, gender, age, social class, and having an urban or rural upbringing. Moreover, reflected in health policy and philosophies of mental health care are the cultural majority’s beliefs about ‘abnormality’, which exert an important influence on the course and outcome of ‘multicultural clinical interactions’ (Fitzgerald, 1992; Fitzgerald, et al., 1997a). The explanatory models of individual practitioners and service users may therefore, be a secondary influence on ‘multicultural clinical interactions’.

Furthermore, the mental health practitioner’s explanatory model may not be fully conveyed to a service user and their family members, thus leading to communication breakdown. In many cases, this breakdown is a consequence of ‘language discordance’ (e.g., between the mental health practitioner and the service user), but extra linguistic and cultural factors can come into play (Sobo and Seid, 2003; Sobo, 2004; 2009). Miscommunications during ‘multicultural clinical interactions’ (Fitzgerald, 1992) occur even when adequate translation is not an issue (Clark, de Baca, Reidy and Turner, 2002). As Sobo and Seid (2003, p. 98), explained: “the content of what is communicated may be poorly understood if it is not explained in terms that are familiar to the listener”. This is a critical issue in ‘multicultural clinical interactions’, because as Hahn (1995), Good and Good (1993), and Bonder, Martin

and Miracle (2002) have discussed, the intensive training that a health practitioner receives may create a gulf with their service users. In other words, all clinical interactions are multicultural (Fitzgerald, 1992).

According to the medical anthropologist Elisa Sobo (Sobo and Seid, 2003; Sobo, 2004; 2009), if mental health practitioners are to better serve people from all cultures, including ones that are similar to their own, they should develop 'communicative competence'. 'Communicative competence' is about the care that must be taken when translating technical terms into lay language and how "the content of the conversation must be made culturally relevant" to the service user and their support network (Sobo and Seid, 2003, p. 98).

'Insight' and 'Explanatory Models'

Traditional Definitions of 'Insight' and its Clinical Implications

The examination of 'insight' is a salient component of clinical examination and phenomenology, and is used as a diagnostic criterion of schizophrenia⁹. Its definition can be traced back to the work of Aubrey Lewis (1933) and Karl Jaspers (1959), who distinguished between awareness of illness and a lack of insight. In 1933, Aubrey Lewis (1933) defined 'insight' as a correct attitude to morbid change in oneself and the realisation that the illness is mental. Similarly, in the 1970's, Carpenter, Strauss and Barktko (1973), described lack of insight as a symptom of schizophrenia which was evaluated as being merely present or absent.

These traditional conceptualisations of the clinical concept of insight have supported the view that insight is absent in psychosis and that it is an all or none phenomenon (Saravanan, et al., 2005; Chakrabarty and Basu, 2010). For example, 97% of patients examined in the 'International Pilot Study of Schizophrenia' (World Health Organization, 1973) were recorded as not having insight (Wilson, Ban and Guys, 1986). Using these categorical definitions, insight is assessed by instruments such as the 'positive and negative syndrome scale' (Kay, Fisbein and Opler, 1987). This categorical or unitary assessment of insight has resulted in many people with schizophrenia not meeting the required standard (Jacob, 2010).

⁹ As in the 'Flexible System' and the 'Present State Examination' (Endicott, et al., 1982).

'Multidimensional' Definitions of 'Insight'

The traditional uni-dimensional measurement (e.g., Lewis, 1933; Jaspers, 1959; Carpenter, Strauss, and Barktko, 1973) of insight has been replaced with multidimensional perspectives (e.g., David, 1990; Amador and David, 1998; Mintz, Dobson and Romney, 2003). Multidimensional constructs of insight have been supported empirically (e.g., Greenfield, Strauss, Bowers and Mandelkern, 1989; Zimmerman, 1991; David, Buchanan, Reed and Almeida, 1992; Birchwood, et al., 1994). The convention in psychiatric practice now is to follow Amador and David's (1998) multidimensional conceptualisation of insight, which includes: (1) awareness of mental disorder; (2) understanding of the social consequences of disorder; (3) awareness of the need for treatment; (4) awareness of specific signs and symptoms of the disorder; (5) the attribution of symptoms to the disorder.

Instruments also have been devised to assess and quantify insight. These instruments have included the 'Insight and Treatment Attitudes Questionnaire' (McEvoy, Apperson and Applebaum, 1989), the 'Schedule for Assessment of Insight' (David, 1990), and the 'Scale to Assess Unawareness of Mental Disorders' (Amador, Strauss, Yale and Gorman, 1991). Moreover, the psychiatric literature has indicated that insight is a good indicator of compliance with treatment and prognosis and greater quality of life (McEvoy, Freter and Everett, 1989; Buchanan, 1992; Kemp and Lambert, 1995; McGorry and McConville, 1999).

However, these types of study have largely been conducted in Western countries and with cultural majority derived samples, and therefore, the cross-cultural validity of the clinical measurement of insight has not been adequately addressed (Saravanan, et al., 2004). It is evident from these traditional (e.g., Lewis, 1933; Jaspers, 1959; Carpenter, Strauss and Barktko, 1973) and multidimensional (e.g., David, 1990; Amador and David, 1998; Mintz, Dobson and Romney, 2003) definitions of insight that the mainstream psychiatric research literature focus has been on the supposed psychological and neurological basis of insight, in that the loss of awareness of deficits and denial of illness are ascribed to whatever disease process underlies mental illness (Johnson and Orrell, 1996). That is, the clinical

concept of insight employs biomedical conceptions of 'disease' (Eisenberg, 1977) and psychopathology (Saravanan, et al., 2007a).

Unsurprisingly, much of the mental health nursing literature has taken up the issue of insight at the point of treatment compliance (Pinkihana, Happell, Taylor and Keks, 2002; Coombs, Deane, Lambert and Griffiths, 2003). According to Hamilton and Roper (2006), this concern reflects the pragmatic nursing interest about whether a service user warrants more or less nursing attention, and more specifically, whether the service user takes or refuses the prescribed medication. The nurse's primary role is to administer treatment, rather than judge diagnoses (Hamilton and Roper, 2006) and hence, the reason why the nursing literature has been quiet on the issue of whether service users possess insight or at what level.

'Insight' and the Influence of Culture

The more recent 'multidimensional' definitions of insight (e.g., David, 1990; Amador and David, 1998; Mintz, Dobson and Romney, 2003) have been criticised from cultural perspectives (Lazare, 1989; Littlewood, 1990; Perkins and Moodley, 1993; Johnson and Orrell, 1995; 1996; Beck-Sander, 1998; David, 1998; McGorry and McConville, 1999; Kilshaw, Ndegwa and Curran, 2002; Saravanan, et al., 2004; 2005; 2007a; Hamilton and Roper, 2006; Lipsedge, 2007; Fernando, 2010; Jacob, 2010). In particular, a major criticism of multidimensional clinical conceptualisations of insight is that they still fail (like their traditional uni-dimensional predecessors) to take into account cultural and individual 'idioms' of distress (Nichter, 1981). Explanatory models that are incompatible with the biomedical account of psychopathology are discounted (Littlewood, 1990). Even in parts of the non-Western world, non-biomedical explanatory models are excluded from the clinical assessment of insight (Jacob, 2010). As Jadhav (2000, p. 42) notes:

"Local worlds, their core moral and cultural values, and a rich vocabulary associated with bodily problems and expressed through a range of non-English languages, are often glossed over or pruned to fit into conventional psychiatric nosological systems (DSM and ICD). This process of systematically acquiring a culture-blind ability is considered credible and meritorious, both locally and internationally".

Kilshaw, Ndegwa and Curran (2002, p. 13) explained, that service users "may disagree with their clinician's views that they are ill, not as a result of the illness itself,

but because they hold different beliefs about the nature of mental illness". All mental illnesses in the biomedical model are considered medical diseases, and a failure to subscribe to such a point of view often results in the clinical judgement that the person lacks insight (Jacob, 2010). Kilshaw, Ndegwa and Curran (2002, p. 89), note that assessment is always "derived from the assessor's perspective". Thus, the clinical concept of insight can alternatively be seen as a form of control, as a way of dismissing the service user who resists the practitioner's explanatory model for their distress (Kilshaw, Ndegwa and Curran, 2002). Hamilton and Roper (2006) also have challenged the clinical assumption that in relation to the assessment of a service user's insight, a unitary professional opinion will always emerge. As Hamilton and Roper argue, there are likely to be several practitioners examining a single case-in which case, several different professions may be represented, with opinions informed by biomedical, social, psychological, moral, and common sense ideas.

Research that has examined the clinical interactions between mental health professionals and Afro Caribbean service users in London (Kilshaw, Ndegwa and Curran, 2002) has problematised the clinical concept of insight. In particular, these researchers found that practitioners' use of the 'Birchwood Insight Scale' (Birchwood, et al., 1994), revealed far more about a service user's disagreement with psychiatric intervention and medication than it did about awareness of mental illness. Such scales are problematic, as insight depends on a service user acknowledging that they have a mental illness and not any other problems. Kilshaw, Ndegwa and Curran (2002) presented a case example of a service user who perceived that something was wrong with them, yet ascribed the cause to a non-biomedical explanatory model (in this case, the service user attributed the cause of their distress to the practices of voodoo), had the same extremely low score on the insight measure as someone who felt there was absolutely nothing wrong with them. The clinical concept of insight had no cultural validity for this service user. This finding is not surprising, as the concept of insight itself is a western clinical construct (Kilshaw, Ndegwa and Curran, 2002).

'Multidimensional' clinical measurements of insight (David, 1990; Amador and David, 1998; Mintz, Dobson and Romney, 2003) fail to acknowledge that people with psychiatrically defined mental disorders may hold multiple explanatory models for their distress (Saravanan, et al., 2004). As Kleinman (1980) has suggested, a

service user's explanatory models for their distress may be diverse and contradictory. Research studies that have examined the cultural validity of the clinical concept of insight in India (e.g., Saravanan and Jacob, 2006; Saravanan, et al., 2007a; b) have highlighted that many people who were diagnosed with schizophrenia had simultaneously held multiple and often contradictory explanatory models about the causation of their illness and help seeking strategies. In such, cases 'personalistic' (Eisenbruch, 1990) beliefs about illness causation (e.g., beliefs in karma, sin, punishment, evil spirits, black magic, and other supernatural and moral explanations), as well as 'naturalistic' explanatory models (e.g., degeneration, dysfunction) were held simultaneously.

The authors (Saravanan and Jacob, 2006; Saravanan, et al., 2007a; b) of these studies discovered no one to one correspondence between illness causation beliefs and consequent help seeking actions (correspondence between beliefs about the cause of an illness and its resolution is an inherent assumption of the clinical measurement of insight). Help seeking behaviour in particular has a special place in multidimensional conceptualisations of insight. However, this research evidence from India (Saravanan and Jacob, 2006; Saravanan, et al., 2007a; b) suggested that patients and their relatives sought interventions from both the 'professional' sector of biomedicine and traditional healers in the 'folk' sector of the health care system (Kleinman, 1978; 1980; 1984). These explanatory models, which were held simultaneously, together with pluralistic help seeking approaches, reflected the pluralistic perspectives (explanatory models) of these patients and their family members.

These authors' (Saravanan and Jacob, 2006; Saravanan, et al., 2007a; b) conclusions reinforced Kilshaw, Ndegwa and Curran's (2002) research findings on the clinical interactions of Afro Caribbean service users, confirming that current multidimensional measurements are not culturally sensitive in their assessment of insight. They also suggest that it is difficult to have definable, objective, or universal measures for clinical insight (Saravanan, et al., 2005). Thus, the clinical measurement of insight signifies in a variety of ways in which a person's mental life must approximate to that of others (e.g., the explanatory models of biomedicine), in terms of what constitutes a psychiatric defined mental illness, what beliefs are

considered 'abnormal,' and what help seeking behaviour is it reasonable to follow (Saravanan, et al., 2004).

In some cultures, the diagnostic label of a mental illness is highly stigmatising¹⁰, and there is some evidence to suggest that service users may seek to protect themselves from the stigma of mental illness by denying their illness, or by somatising, rather than psychologising their distress (Kennard, 1979; Lally, 1989; McGorry, 1992; Johnson and Orrell, 1995; Hsu, 1999; Hudelson, 2005; 2006; Perron and Hudelson, 2006; Lipsedge, 2007). Likewise, the denial of illness has been associated with the unacceptability of psychiatric treatment (Johnson and Orrell, 1995). As some academics have argued (e.g., Fernando, 1988; 1998; 2002; 2009; 2010; Littlewood and Lipsedge, 1997; Bhugra and Bahl, 1999; Bhui, 2002; Kilshaw, Ndegwa and Curran, 2002; Ndegwa and Olajide, 2003; Sewell, 2009), these issues may be particularly salient to groups such as the African-Caribbean community in the UK, who may feel fearful of psychiatry and the treatment it offers. Indeed, resisting labels and explanatory models that have been applied to their distress may be seen as important statements by service users (Kilshaw, Ndegwa and Curran, 2002). In this way, social life can be seen as a 'negotiation of meanings' (Marcus and Fischer, 1999).

For these reasons, the 'lack of insight' label may point to a lack of agreement about the explanatory models used by the practitioner and the service user in understanding the cause, nature, prognosis, and treatment of the service user's distress (McGorry and McConville, 1999). As Beck Sander (1998) suggested, the concept of explanatory model "goes to the heart of many concerns about the usefulness of the global construct of insight" (p. 587). Most importantly, the omission of social and cultural influences in the assessment of insight has negative implications for the care and treatment of service users (Johnson and Orrell, 1995). The stakes are highest "when the mental health system is supported by a legal

¹⁰ There are several negotiable components in the definition of 'stigma' (Hutchinson and Bhugra, 2000), and as such, the concept of stigma is itself negotiable (Link and Phelan, 2001). This is because its meaning is primarily embedded in the sociocultural milieu in which it originates (Kleinman, et al., 1995). A broad conceptualisation of stigma includes: a mark that sets an individual apart; links that individual to some undesirable characteristic; rejection, isolation, and/or discrimination against that individual (Jones, et al., 1984). In addition to the physical mark or label, the process of stigmatisation includes behavioural, cognitive, and sociological characteristics (Hutchinson and Bhugra, 2000).

system where patients can be treated involuntarily” and against their will (Hamilton and Roper, 2006, p. 420). In response to such criticisms, Saravanan and colleagues’ (2004; 2005) have argued for cultural perspectives to be taken into account when a person’s insight is assessed, suggesting that this could be achieved by bringing the assessment of insight into line with the DSM-IV’s (American Psychiatric Association, 1994) recommendations around the assessment of delusional phenomena. In particular, the DSM-IV encourages practitioners to compare the content of a person’s delusions with their local and cultural standards.

Critiques of the ‘Explanatory Model’ (EM) Framework

Despite the strong appeal of the explanatory model framework and its relevancy to understanding ‘multicultural clinical interactions’ (Fitzgerald, 1992), the concept of explanatory model has not been without its fair share of critics (e.g., Thomas, 1978; Taussig, 1980; Young, 1982; Fisher and Todd, 1983; Scheper-Hughes and Lock, 1987; Lazarus, 1988; Parsons, 1990; Campbell, 2000; Williams and Healy, 2001; Dein, 2003). These criticisms have derived from both ‘critical theory’ and ‘deconstructionist’ approaches. Proponents of critical theory have argued that the interpretation of events by social actors and the meanings which they assign to those events are structured by their historical participation in the social hierarchy (Young, 1982). Critical theorists point out that health practitioners and service users have little opportunity to participate in the active construction of explanatory models (Young, 1982). Rather, critical theorists view explanatory models as the outcome of historical and ideological relations of economic and social inequality. A political economy perspective (Farmer, 2003) is therefore, central to the critical theory critique of the explanatory model concept.

Although later accounts of the explanatory model concept (Kleinman, 1988b) have emphasised their fluidity, contradictions, and shifting content, some academics have maintained reservations about the concept. These reservations stem from the view that explanatory models only have limited relevance to the actual process of clinical interactions (Williams and Healy, 2001). In particular, Williams and Healy (2001) have characterised explanatory models as reified devices and as implicitly fixed and static. The issue of language discordance (i.e., between practitioners and service

users) also has been neglected in discussions about the elicitation of and negotiation with service users' explanatory models. As Parsons (1990) has noted; it is not always the case that practitioners and service users are able to communicate coherently in the same language. When language discordance is an issue, and when a medically trained interpreter is not readily available, it may be difficult if not impossible for a practitioner to have any understanding of the service user's explanatory model (Parsons, 1990).

Despite these legitimate criticisms, the explanatory model is integral to the meaning-centred theoretical perspective (Good and Good, 1981; Gaines, 1982a; 1992; Good, 1994). The explanatory model concretises the important anthropological distinction between 'disease' and 'illness' (Eisenberg, 1977) and the related 'etic'-'emic' perspective (Skultans and Cox, 2000). And as I have already pointed out, 'multicultural clinical interactions' (Fitzgerald, 1992) can be conceptualised as the transaction of explanatory models.

Summary

This background chapter has presented 'multicultural clinical interactions' (Fitzgerald, 1992) as the transaction of 'explanatory models' (EM) or different perspectives and 'clinical realities' (Kleinman, 1980). These perspectives, explanatory models, or clinical realities (Kleinman, 1980) are grounded in the important medical anthropological distinction between 'disease' and 'illness' (Eisenberg, 1977) and the related 'etic'-'emic' paradigm (Skultans and Cox, 2000). Embedded as they are in culturally variant conceptions of the 'self' (White and Marsella, 1982; Seeley, 2006) and 'cultural theories of (domains) Illness' (Helman, 2000; 2007), explanatory models provide context to an alternative understanding of 'insight' (Jacob, 2010) and other salient cultural issues that may emerge for pre-registered mental health student nurses in clinical placement. The next chapter relates this discussion of explanatory models to the 'normative uncertainty' evaluation dilemma (Good and Good, 1986).

Chapter 3

‘Abnormality’ or ‘Normality’: The ‘Normative Uncertainty’ Evaluation Dilemma and ‘Multicultural Clinical Interactions’

“The two forms of examination, whether they stem from the sick or healthy man, set up a standard of normality, and it is exactly here, before starting with our main theme, that our difficulties begin. We do not know what normal is, and what an exact definition of normality consists of. Our conceptualizations of normality differ considerably, depending on our orientation, be it cultural, social, psychological, or medical”.

(Hirsch, 1962, p. 85)

Introduction

‘Multicultural clinical interactions’ (Fitzgerald, 1992) can present assessment dilemmas for mental health practitioners. More specifically, the research literature describes at least two problematic clinical areas where these assessment dilemmas emerge for practitioners in practice. Firstly, the practitioner may face difficulties in differentiating religious rituals from the rituals that may be symptomatic of obsessive compulsive disorder (OCD) (Good and Kleinman, 1985; Greenberg and Witztum, 1991; 2001; Guarnaccia, 1997; Guarnaccia and Kirmayer, 1997; Kirmayer, Young and Hayton, 1997; Al-Issa and Oudji, 1998; Yossifova and Loewenthal, 1999; Kirmayer, 2001; de Silva and Bhugra, 2007; Loewenthal, 2007; Rego, 2009). Secondly, the practitioner can encounter the dilemma of having to distinguish between ‘normative’ religious beliefs, behaviours, and experiences, and psychotic illness (Gaines, 1988; 1995; Loewenthal, 1995; 2006; 2007; Dein, 2000; 2004; 2010a; b; Lu, 2004; Bartocci and Dein, 2007; Tobert, 2007; 2010).

At the same time, this ‘normative uncertainty’ evaluation dilemma (Good and Good, 1986) manifests itself in other ways and will occur in any clinical situation where a practitioner faces the dilemma of distinguishing between mental illness and culturally supported behaviours and personality traits (Galanti, 2008). When it comes to understanding service users’ ‘idioms of distress’, culture and beliefs about how culture influences behaviour can create considerable confusion for practitioners.

In the absence of clear diagnostic and assessment criteria that distinguish between 'culture' and 'psychopathology' (Andary, Stolk and Klimidis, 2003; Tseng and Streltzer, 2008; Stolk, 2009), practitioners have been reported as relying on their own intuition and 'gut instincts' (Eeles, 2001; Eeles, Lowe and Wellman, 2003), or seeking out possible 'strategies' or 'procedures'¹¹ (Romiszowski, 1984) from a contradictory and confusing cross-disciplinary evidence base. While scholars (e.g., Helman, 1984; Lovinger, 1984; Westermeyer, 1987; Jackson and Fulford, 1997; Lefley, Sandoval and Charles, 1998) have made attempts at providing practitioners with such clinical criteria, some of these criteria have been criticised as being too specific to a particular belief system, or for including dubious criteria (Andary, Stolk and Klimidis, 2003; Stolk, 2009). However, the decontextualisation of service users' experiences results in the pathologisation of culturally 'normative' phenomena, 'category fallacy' errors (Kleinman, 1977; 1988a), and poor health care experiences and outcomes for service users (Fitzgerald, et al., 1997a; Callan and Littlewood, 1998; Kilshaw, Ndegwa and Curran, 2002).

Having discussed these concerns and the problems that arise from the 'normative uncertainty' evaluation dilemma (Good and Good, 1986), the final sections of this background chapter will situate this dilemma within a wider debate that has concerned both the biomedical and social sciences-the unresolved difficulty of defining 'normal' and 'abnormal' (Helman, 2000; 2007; Fernando, 2002; 2010; Winkelman, 2009). Indeed, this debate is intimately tied to wider cultural ideas about what is considered 'normal' (Dillard, et al., 1992; Swartz, 1998). The disciplines of psychiatry, psychology, and medical anthropology have struggled to establish workable criteria against which to judge behaviour as 'normal', 'abnormal', or 'pathological' (Offer and Sabshin, 1966; Good and Good, 1986; Tseng, 1997; Stevenson, 2010). Three models for understanding mental 'abnormality' are evident in cultural psychiatry and these models have corresponded closely to the interpretive models used by anthropologists attempting to make sense of the apparent diversity

¹¹Romiszowski (1984, p. 110) defined a strategy as "a schema of interrelated general principles", and a procedure as "a fixed sequence of steps that should be performed to achieve a given aim". Mental health practitioners need access to resources and strategies to help them in clinical problem solving (Fitzgerald, et al., 1997a). However, problems arise when such resources are used in an unquestioning fashion, or are viewed as procedures or 'recipes' for success (Fitzgerald, et al., 1997a; Gunaratnam, 1997; 2001).

of human societies (Shweder and Bourne, 1982; Fernando, 1988; Helman, 2007; Berry, Poortinga, Breugelmans and Chasiotis, 2011). The three models of 'absolutism', 'universalism' and 'cultural relativism' not only have important consequences for the nature and conduct of research enquiry (Kleinman, 1988a), but also have implications for how the 'normative uncertainty' (Good and Good, 1986) evaluation dilemma is attended to in practice. As they are discussed in the context of the 'normative uncertainty' evaluation dilemma, the concepts of religion and spirituality are central to this background chapter. I will therefore, begin this background chapter with a conceptual overview of these two related, but distinct concepts.

Religion and Spirituality: Similar, but Distinct Concepts

Since the 1990's, the mental health literature has differentiated between the concepts of religion and spirituality (Zinnbauer, et al., 1997; Speck, 1998; Fernando, 2002; 2010). While spirituality is a common feature of different religious traditions, it also is possible to be spiritual outside the context of organised religion (King and Dein, 1999; Loewenthal, 2007). Both of these terms are fuzzy concepts (Fernando, 1988; 2003). However, religion usually refers to "socially based beliefs and traditions, often associated with ritual and ceremony", whereas spirituality generally "refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater 'whole', together with a sense of belonging and acceptance" (Dein, Cook, Powell and Eagger, 2010, p. 63).

Scholars have tended to agree that religion involves affiliation and identification with a religious group, cognitive factors (beliefs), and emotional and experiential factors (Ember and Ember, 1988; 1992; Shafranske and Maloney, 1996; Winkelman, 1999; 2005). Although some religious systems do not have beliefs concerning the existence of supernatural beings, the belief in supernatural beings is a defining feature of many religions (Dein, 2000). The monotheistic religions also hold the view that the source of existence (i.e., God as a spiritual being) is also the source of moral directives (Loewenthal, 2007). Dein (2000) has recommended the usage of the alternative term of 'ultimate reality' in place of supernatural beings. According to Dein, this ultimate reality is set apart from mundane earthly reality and is treated as 'sacred'. Through the enacting of religious rites, a person may be able to enter this

sacred reality, and for a time transcend their mundane existence and earthly troubles. All the major religions depend on social organisation for communicating their ideas and practices (Fernando, 2002; 2010).

Anthropologists have found that ritual is characteristic of all religious systems (Winkelman, 1999; 2005). Although there is some debate around the definition and meaning of 'ritual', most anthropologists would agree that the term refers to a form of repetitive behaviour that often has an element of symbolic communication and therefore, does not have a direct instrumental effect (Dein, 2000). Religion like spirituality is firmly embedded in culture and may be a major part of a person's worldview (Winkelman, 1999; 2005). As Fitzgerald and colleagues' (1997a) note, religion explains both the natural and the supernatural world, the relationship between the two realms, and the place of humans in the universe. For many people, religion is an integral part of how they view life, how they relate to others, and is a source of beliefs, values, and behaviours (James, 1961; Browning, Gobe and Evison, 1990; Krippner and Welch, 1992). Religion may both reflect and validate the social order, and influences how people should and should not behave (Tseng and McDermott, 1981).

In the social sciences, the topic of 'religious experience' has been marginalised (Dein, 2011); however, it is important to this background review. Although, William James (1961) considered religious experiences to be pre-cultural and pre-cognitive, Simon Dein (2011) in a recent paper has argued against this perennialist position, by suggesting instead that such experiences and their narration are culturally constructed. Dein (2010b, p. 524) also explains, that "religious experiences are polythetic in the Wittgenstein sense, as having 'family resemblances' rather than possessing a single criterion that they all must share". Religious experiences have been associated with a variety of labels "including mystical, ecstatic, numinous, born-again, anomalous, paranormal, out-of-body, flow, transcendental, and conversion experiences" (Dein, 2010b, p. 524). Based on a survey of the 'Alister Hardy Society' archives, Jakobsen (1999) found that people in Western societies tended not to share their negative religious experiences for fear of being labelled as mentally ill.

The meaning of 'spirituality' has been discussed extensively in the nursing research literature (e.g., Narayanasamy, 1999; Narayanasamy and Owens, 2001; Tanyi,

2002). This literature, however, has particularly focused on the following agreed dimensions: A search for fulfilment and meaning; finding a purpose in life; relationships with others; an individual's essence as a person; and as something which integrates the mind, body, and the emotions (McEwen, 2005). Spirituality may be expressed through art, poetry, and myth, as well as religious practice (Dein, Cook, Powell and Egger, 2010). Spirituality is thus a more inclusive concept than religion (Dein, 2000; 2004; 2010a). When a service user's distress is coloured by religion or spirituality, it may be difficult for a practitioner to differentiate between what is 'culturally normative' and what is 'psychopathological' (Kilshaw, Ndegwa and Curran, 2002).

The 'Culture' or 'Psychopathology' Clinical Dilemma

This discussion of the 'culture' or 'psychopathology' clinical dilemma is related to the previous background chapter on 'explanatory models' (Kleinman, Eisenberg and Good, 1978), the clinical concept of 'insight' (Jacob, 2010), cultural conceptions of 'self' (Seeley, 2006), and their influence on practitioners' 'multicultural clinical interactions' (Fitzgerald, 1992). Fitzgerald and colleagues' (1997a) are among only a few researchers (also see Sanderson, Vandenberg and Paese, 1999; Eeles, 2001; Eeles, Lowe and Wellman, 2003; Tobert, 2007; Stolk, 2009) who have explored empirically the clinical implications of this dilemma. They (Fitzgerald, et al., 1997a) found that occupational therapists working in mental health service settings were ill prepared and lacked the knowledge to satisfactorily address the problems presented by the 'culture' or 'psychopathology' dilemma. The occupational therapists expressed doubt about whether a service user's beliefs and behaviours was evidence of an underlying psychopathology, or of cultural differences in 'normative' experience. To take this dilemma one stage further: "When are such things the product of illness and when are they products of culture" (Fitzgerald, et al., 1997a, p. 91)? Are they always both and if they are both, when can they be considered as both?

Gaines (1995) suggests that it may not be possible to make a sharp distinction between 'culture' and 'psychopathology', since "rarely is a mind so disordered...that even in illness it does not make extensive use of cultural materials, whether negatively, that is, against society or not" (p. 282). Even when 'organic' psychiatric

disorders are considered the content of hallucinations¹² and delusions¹³ reflect the way a given community structures experiences (Weinstein, 1962; Gaines, 1988). Traits that a person displays may not necessarily be symptomatic of psychiatrically defined illness, but part of his or her orientation to culture (Galanti, 2008). These dilemmas arise not only for practitioners but are central questions in disciplinary fields that focus on transcultural mental health (Prince, 1979; Fernando, 1988; 2010; Swartz, 1998; Winkelman, 2009).

The way that practitioners deal with such questions or dilemmas has important implications for their service users (Minas, 1991; Good, 1996). Failure to understand the influence of culture on a service user's behaviour and beliefs can result in two main types of assessment errors (Rack, 1982; Fitzgerald, et al., 1997a; Dein and Lipsedge, 1998). First, culture naiveté on the part of the practitioner may result in culturally sanctioned phenomena being misdiagnosed as mental illness. For example, 'glossolalia' may be misdiagnosed as 'schizophrenic speech disorder' and 'possession' as 'schizophrenic passivity' (Littlewood and Lipsedge, 1997). In such a case, when a person is not distressed, but is perceived as being ill, an injustice may be done and limited resources used to address a problem that does not exist (Fitzgerald, et al., 1997a).

Second, there is a risk that the reverse may apply—a practitioner may assess the signs and symptoms of mental illness as cultural differences (Fitzgerald, et al., 1997a). In such a case, the service user's distress may not be adequately addressed, and in the worst case scenario, the service user will be harmed in some way (Dein and Lipsedge, 1998). This error can be attributed to what Stein (1985) has

¹² Hallucinations are traditionally defined in psychiatry as perceptions, which lack sufficient basis in external stimuli, even though the person places their origin in the outside world (Leff, 1981). These perceptions can be auditory or even relate to taste and smell (Al-Issa, 1977; Westermeyer, 1987; Vega, et al., 2007; Vespia, 2009).

¹³ The term 'delusion' in psychiatry has traditionally denoted an erroneous belief that is nonsensical to others and which is held in the face of evidence to the contrary (Oltmanns, 1988). This definition encompasses the key elements of a delusion as originally formulated by Karl Jaspers (1968): 'Falsity', 'subjective certainty', and 'incorribility'. More recently, a 'dimensional' approach has been proposed (Pierre, 2001). 'Conviction', 'preoccupation', 'negative affect', and 'extension' (the degree to which the delusion affects a person's life) are considered as dimensions of delusions (Kendler, Glazer and Morgenstern, 1983; Garety and Hemsley, 1994; Applebaum, Clark Robbins and Roth, 1999). The DSM-IV also refined the definition of a delusion to one that is not "ordinarily accepted by other members of the person's culture or subculture" (American Psychiatric Association, 1994, p. 765).

referred to as 'culture as a red herring', which is revealed when a practitioner begins to treat individuals differently simply on the basis of their presumed cultural background. As Stein (1985, p. 4) argues, a "clear distinction must always be made between what a patient's culture is and what clinicians presume it to be". Other assessment errors may also occur-a wrong diagnosis may be given, or the severity of the illness may be under or overestimated (Fitzgerald, Mullavey- O'Byrne, Twible and Kinebanian, 1995).

Littlewood and Lipsedge (1997) have placed the perception of mental abnormality along a dynamic spectrum, ranging from the organic psychiatric illnesses such as dementia, which have a defined biological aetiological basis, to what they regard as the vaguer and more diffuse patterns of 'adaptive' or 'maladaptive' behaviour that can only be examined and assessed in relation to the cultural context. In the case of the organic psychiatric illnesses, there are measures of physical abnormality, such as changes in body temperature or blood chemistry-which are similar to those measures available in general medicine-the 'form' of organic psychiatric illnesses are very similar across cultural contexts. By contrast, the patterns of behaviour at the social end of the spectrum (e.g., suicide attempts or delinquency) are only recognised as being 'abnormal' according to "the norms of behaviour in a particular community at a particular time" (Littlewood and Lipsedge, 1997, p. 191). These patterns of behaviour at the social end of the spectrum are more likely to be perceived as the consequence of free will, than those conditions at the biological end of the scale.

Located in the middle of this spectrum lies the most problematic area of mental 'abnormality'- the psychoses (e.g., schizophrenia) and neuroses (e.g., phobias and anxiety states). Littlewood and Lipsedge suggest that the psychotic illnesses have greater affinities with the biological end of the spectrum, while the neuroses seem closer to the social end. However, they also note that the description of mental illnesses as each being located somewhere along this biological-social spectrum is somewhat over-simplified. Indeed, they argue that the perception of psychological 'abnormality' is itself filtered by cultural norms. As Raymond Prince (1992, p. 289) explained:

“Highly similar mental and behavioural states may be designated psychiatric disorders in some cultural settings and religious experiences in others...Within cultures that invest these unusual states with meaning and provide the individual experiencing them with institutional support; at least a proportion of them may be contained and channelled into socially valuable roles”.

The Pathologisation of Religion and Spirituality in Clinical Practice

For many people the religious and spiritual dimensions of culture are among the most important elements that structure their experiences, beliefs, values, behaviours and ‘explanatory models’ and ‘help seeking’ (Chrisman, 1977; Kleinman, 1980; Browning, Gobe and Evison, 1990; Krippner and Welch, 1992). However, scholars (Freud, 1907; 1961a; b; Ellis, 1980; 1986; Dawkins, 2006) and professional bodies (Group for the Advancement of Psychiatry, 1976) from the biomedical and psychological sciences have regarded religious and spiritual beliefs as delusions, on the basis that religion and spirituality is inherently fabricated and therefore, the beliefs that are associated with it are false. Perhaps it is not surprising that the theologian Hans Kung (1986) has referred to religion as psychiatry’s last taboo.

Such an attitude has also been shown to exist among mental health practitioners (Lukoff, Lu and Turner, 1995; Bhugra, 1996; Fry, 1998; King and Dein, 1999; Fernando, 2003; 2010), whom according to Lukoff, Lu and Turner (1992, p. 673), “have tended to either ignore or pathologize the religious and spiritual dimensions of life”. As a result, “individuals who bring religious and spiritual problems into their treatments are often viewed as showing signs of mental illness” (Lukoff, Lu and Turner, 1992, p. 673). Thus, the risk of a ‘prejudicial’ analysis of religious phenomena is high (Crossley, 1995). In such a situation, a misdiagnosis and ‘category fallacy’ (Kleinman, 1977; 1988a) error can occur, the service user may be detained against their will, be given inappropriate treatment, and suffer iatrogenic harm (Bragdon, 1993; Charters, 1999).

A focused ethnography on the clinical interactions between practitioners and Afro-Caribbean service users in mental health service settings in London found a prevailing negative attitude among practitioners towards the issues of religion and spirituality (Kilshaw, Ndegwa and Curran, 2002). In some cases, service users’ religious or spiritual concerns were not assessed in their cultural contexts, but were just assumed to be aspects of psychopathology. Kilshaw, Ndegwa and Curran

provided a clinical case example of this—a service user was told on several occasions by staff members that their religiosity pointed to schizophrenia. These statements heightened this service user's feelings of alienation and sense they were not being listened to. Other researchers (Lukoff, Lu and Turner, 1996; Johnson and Friedman, 2008) have suggested that service users may feel increasingly isolated and misunderstood when their religious or spiritual beliefs, and accompanying behaviours and experiences, are ignored or misdiagnosed as psychopathology. This again may also lead to adverse outcomes, including blocking any future attempts at help seeking.

The picture seems more mixed in the psychiatric nursing literature, with academic attention being placed more on the concept of spirituality than religion. While some scholars (Narayanasamy and Owens, 2001; Vandover and Bacon, 2001; Como, 2007) have suggested that spirituality is a valued and integral component of holistic practice, others in the profession have concluded that while most nursing theories and models embrace the concept of holistic practice and describe individuals as having spiritual needs, the concept of spirituality and provision of spiritual care is basically neglected (Oldnall, 1995; 1996; Fry, 1998; Martsoff and Mickley, 1998; Swinton, 2001; Malinski, 2002). Fry (1998) highlighted an attitude among nurses where issues of “religion and spirituality are generally marginal issues bordering on the psychotic or, at least, ‘misguided normal’ and should be ignored in order to focus on reality based issues” (p. 28).

The tendency by practitioners to pathologise service users' expressions of religiosity and spirituality stem from a number of concerns; not least, the role of religion and spirituality in the lives of people diagnosed with severe mental illness (Sims, 1992; 1994; Clarke, 2001); the not infrequent religious content of delusions and hallucinations (Sims, 1995; Siddle, 2000; Koenig, 2007); and the ‘normative uncertainty’ evaluation dilemma (Good and Good, 1986). It also is fuelled by practitioners concern with liability, when related to ‘command’ hallucinations experienced by some service users (for instance, a person whose homicidal or suicidal impulses are attributed to the voice of God) (Fallot, 1998). Furthermore, when practitioners have looked for associations between religion/spirituality and specific anxiety disorders, ‘obsessive compulsive disorder’ is another category in

which such relationships are assumed to be present (Loewenthal, 2007). Not only have religious obsessions been reported to frequently occur (Tek and Ulug, 2001), but it is possible that practitioners may assume there is some relation between particular clinical features of obsessive compulsive disorder, such as thought-action fusion (i.e., the belief that thinking is equal to doing), perfectionism, rituals, and doubts on the one hand, and religious practices, thought patterns and moral concerns on the other (de Silva and Bhugra, 2007).

The reported (Fry, 1998; King and Dein, 1999; Fernando, 2003; 2010) lack of sensitivity by practitioners to the cultural forces of religion and spirituality in the lives of service users reflects a general and powerful trend in the 'professional' sector of mainstream mental health services in the UK and elsewhere. In other words, the ontological primacy that the mental health professions have historically given to "biology over culture" (Kilshaw, Ndegwa and Curran, 2002, p. 98). This reductionist focus on biological factors (Grof, 1985; Tobert, 2007; 2010) combined with "historical biases against religious and spiritual experiences, impedes culturally sensitive understanding and treatment of psycho-religious and psycho-spiritual problems" (Lukoff, Lu and Turner, 1992, p. 676). This is despite the fact that Judeo-Christian thought has played an influential role in contemporary conceptualisations of self, agency and personhood (Delaney and DiClemente, 2005). Barrett (2003) argues that Post-Reformation Christian conceptions of the interior and privatized self inform contemporary notions of psychopathology, including the conceptualisation of schizophrenia as involving disturbances of thought.

There may be other reasons why practitioners avoid spiritual or religious issues in clinical practice. Fallot (1998) has suggested that practitioners may be unfamiliar or feel uncomfortable with the content of service users' religious talk. How does a practitioner understand religious experiences and language, especially if they are from a different religious background, or has had painful experiences with religion, or has little interest in or commitment to religious concerns (Loewenthal, 1995)? At the same time it may in practice be more difficult for practitioners to appreciate subtle distinctions regarding religious concerns and activities that are common in their own experience and cultural context (Fallot, 1998).

‘Normative Uncertainty’: Religion, Spirituality, Culture, and the Differential Diagnosis Dilemma

Practitioners are likely to encounter situations where a service user’s distress is so significantly coloured by religion or spirituality that judgements may be required from both the ‘professional’ sector of mental health services and the religious sector (Kilshaw, Ndegwa and Curran, 2002). Differentiating between ‘normative’ religious/spiritual phenomena and psychopathology can be extremely difficult, because of the similarities in phenomenology between pathological symptom expression and the unusual perceptual characteristics and behaviours found in these types of experiences (Prince, 1992; Lukoff, Lu and Turner, 1995; Levy, 1996; Littlewood and Lipsedge, 1997; Lu, 2004; Matthews and Tseng, 2004; Loewenthal, 2007). Good and Good (1986) have defined this clinical concern as “the problem of normative uncertainty” (p. 11). In that, one of the major difficulties facing practitioners, “is to determine whether particular behaviours or forms of experience are abnormal and therefore a symptom of illness or simply different but normal within the patient’s own cultural context” (Good and Good, 1986, p. 11). However, at the same time, cultural judgements about ‘normalcy’ often masquerade in diagnostic manuals and instruments as scientific objectivity (Good and Good, 1986).

A case study (Guarnaccia and Rodriguez, 1996) of three ‘Bilingual, Bicultural Psychiatric Programs’ (BBPP) for ‘severely mentally ill’ Hispanic individuals in New York City illustrates this dilemma of ‘normative uncertainty’. Hearing voices was a prominent feature of client reports (a classic symptom of schizophrenia). However, both the content of the client reports (e.g., hearing one’s name called when there was no one there), and the contexts in which they appeared also suggested the possibility that these voices were related to cultural expectations and religious beliefs. Guarnaccia and Rodriguez reported that one of the programs received a referral for a client who kept claiming that he could see a dead relative. The referring agency had assumed he was hallucinating and needed to be admitted for inpatient care. However, staff members working at the BBPP were able to assess the non-delusional nature of the client’s experience, and thus were able to aid the person and return him to the community. The authors of this study note that while “caution is needed not to stereotype all Hispanics as believing in spirits and spiritual healing, it

is also important to explore the possibility that the client's own understandings of auditory hallucinations may be related to these beliefs" (Guarnaccia and Rodriguez, 1996, p. 430). Thus, specific symptoms may have particular cultural meanings, which present challenges to the assessment process, and without some cultural knowledge of these experiences and assessment questions that tap these dimensions, accurate diagnostic judgements using standard psychiatric nosology are difficult to make (Guarnaccia, et al., 1992).

To my knowledge, only one study (Eeles, 2001; Eeles, Lowe and Williams, 2003) has specifically examined how mental health nurses assess the clinical significance of spiritual and religious experiences. Using semi-structured interviews, which incorporated vignettes of spiritual type experiences, this study showed how 14 UK registered nurses employed a complex and inter-relating set of criteria when attempting to distinguish between spiritual experiences and psychopathology. Not only was the nature of the spiritual experience considered by the nurses involved in the study, but the outcome of the experience (positive or negative) was an important evaluative factor, together with the personal and cultural context in which the experience occurred. These nurses also reported using their intuition and 'gut instincts', and emphasised the importance of close engagement with service users to achieve a rounded and holistic view of their experiences. Furthermore, team working was reiterated as a way of reducing idiosyncratic decision making, and a nurse's holistic assessment of spiritual experiences was combined with a tolerance of ambiguity and an awareness of one's own subjectivity. Moreover, while the nurses identified that spiritual experiences could cause distress, at the same time, they identified that individuals diagnosed with severe mental illnesses could also have genuine spiritual experiences-it was not necessarily the case that a person would experience either one or the other. From the perspective of 'meaning centred' medical anthropology (Good and Good, 1981; Gaines, 1982a; 1992; Good, 1994), this study is important, as it highlights the need for nurses and other mental health professionals, to assess spiritual experiences within their cultural contexts. A limitation of this research however, is that the study did not combine the semi-structured interviews with actual observations of how nurses evaluate the clinical significance of spiritual experiences during practice.

As psychotic episodes are associated with changes in previous beliefs and levels of functioning, some prior knowledge about the service user may be important when addressing concerns about 'normative uncertainty' (Good and Good, 1986). At the same time, applying this prior knowledge is problematic when very gradual changes have occurred and beliefs have evolved over time (Kingdon, Siddle, Farooq and Rathod, 2010). Paradoxically, radical changes in beliefs such as 'being born again' can signify a religious experience, but can also occur with psychotic beliefs. It has also been suggested (Kingdon, Siddle, Farooq and Rathod, 2010) that it may be less problematic for the practitioner to detect a psychotic episode when the person has not previously expressed an interest in religious or spiritual matters, and when there is a noticeable increase in the intensity of a person's religious or spiritual interests. Although such changes may point to distress and psychopathology; "it is not uncommon for people to use familiar, yet previously unaccessed belief systems to explain and cast meaning on their experiences" (Kilshaw, Ndegwa and Curran, 2002, p. 98). Paloutzian, Richardson and Rambo (1999) note, there is little evidence to suggest that religious conversion is dysfunctional, or that those people converting from one religious tradition to another become more judgemental, hostile, or coercive towards other people. Some studies (e.g., Bhugra, et al., 1999; Bhugra, 2002a) also show that changes in religious activity follow, rather than precede, a psychotic episode. Even in cases when severe mental illness is evident, there is a therapeutic value in assessing a person's religious or spiritual ideations to salvage the 'normative' dimensions of their experience (Bradford, 1985).

As previously noted, it can be difficult for practitioners to differentiate between hyper religiosity and 'obsessive compulsive disorder'¹⁴ (Good and Kleinman, 1985; Guarnaccia and Kirmayer, 1997; Al-Issa and Oudji, 1998; Kirmayer, 2001; Bartocci

¹⁴ 'Obsessive compulsive disorder' is classified as a major anxiety disorder and is well described in the research literature (see de Silva and Rachman, 2004; Rego, 2009). The essential features of 'obsessive compulsive disorder' are recurrent obsessions or compulsions that are severe enough to be time consuming or cause marked distress, or significant impairment (American Psychiatric Association, 1994). These compulsive behaviors are mostly associated with overt motor action (e.g., repetitive hand washing, checking things, touching, and arranging objects), but they can also be internal or covert (e.g., counting backwards from ten to one or silently saying a prayer a fixed number of times). In most cases, obsessions and compulsions are interlinked. The obsession generates discomfort and/or anxiety, which is dissipated, albeit temporarily, by the successful completion of the compulsive behavior (de Silva and Bhugra, 2007).

and Dein, 2007; de Silva and Bhugra, 2007). In cultures where the regular performance of both public and private rituals may be central, the assessment of obsessive compulsive disorder is complicated by the need to ascertain when the ritual behaviour has become psychopathological (Kirmayer, Young and Hayton, 1997). Important life transitions, rules about protecting oneself from 'pollution' and mourning observances may lead to an intensification of ritualistic behaviours, which without considering their cultural context may be viewed as evidence of obsessive and compulsive behaviour (Guarnaccia, 1997).

Superficially, religious rituals and obsessive compulsive behaviours share some common characteristics, such as the prominent role of cleanliness and purity, the need for rituals to be carried out in specific ways and a set number of times, and the fear that arises from performing the ritual incorrectly (Lukoff, Lu and Turner, 1995). An article by Dulaney and Fiske (1994) compared ritual behaviours from a wide range of cultural contexts with compulsions that were identified in psychiatric texts, and found considerable parallels between the specific behaviours carried out during rituals and by people with obsessive compulsive disorder, though there were marked differences in the motivations underlying these behaviours. In the performance of rituals, the behaviours are part of a cultural meaning system that brings order to the world, whereas in obsessive compulsive disorder, behaviours occur in isolation and with meanings that are regarded as bizarre and of doubtful efficacy by others in the service user's community and potentially, by the service user themselves. According to Dulaney and Fiske (1994, p. 247-248), it "is this meaninglessness and incompatibility, not the morphology of the actions or the content of the thoughts, that constitutes OCD". This notion furthers the concern that the clinical application of the 'obsessive compulsive disorder' diagnosis may be more complex than many practitioners appreciate (Guarnaccia, 1997).

Furthermore, the clinical significance of religious activity and behaviour remains a concern for both comparative psychopathology and clinical practice (Littlewood, 1983; Dein and Littlewood, 2007). Greenberg and Witztum (1991; 2001) present an example from their research, in which an individual whose concern with correctly saying his prayers led him to spend nine hours a day in prayer, instead of the usual forty to ninety minutes spent by other Ultra-Orthodox Jews engaged in this practice.

Even the 1971 report of the 'Anglican Commission on Christian Doctrine' suggested that the practice of prayer could at times lead to doubts over a person's sanity (Brown, 1994). 'Category fallacy' (Kleinman, 1977; 1988a) errors can occur when practitioners are unfamiliar with the context and basic tenets of a religion's beliefs and practices (Greenberg and Witztum, 1991; 2001; Dein, 2000). As Loewenthal (2007) notes, if one knows that a religious tradition requires cleanliness before prayer or purification from sin by confession for example, it may be tempting to conclude that obsessive-compulsive disorder may be fostered by these religious demands and by the over-zealous wish for spiritual purity. Despite research evidence (e.g., Greenberg and Witztum, 1991; 2001; Lewis, 1998) indicating that religiosity is associated with non-clinical scrupulosity and does not actually cause obsessive compulsive disorder, there remains a persistent diagnostic bias. Gartner and colleagues' (1990), Yossifava and Loewenthal (1999), and Lewis (2001), have all found that clinicians, clinical trainees, and lay people were more likely to assess a person as suffering from obsessive compulsive disorder when that person was described as being religiously active.

The 'Category Fallacy' Error

Related to the anthropological distinction between 'disease' and 'illness' (Eisenberg, 1977) is Kleinman's (1977; 1988a) concept of 'category fallacy' error. A 'category fallacy' error occurs when 'illness' (Eisenberg, 1977) as defined and experienced by the service user is made to fit in with psychiatric nosologies and 'explanatory models' (Bhugra and Bhui, 1997). As Kleinman (1988a, p. 14-15) explains, "the reification of one culture's diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not been established, is a category fallacy". The 'disease' perspective is so powerful and convincing to practitioners that it is difficult to think about distress in any other meaningful way (Chrisman, 1991). This difficulty occurs despite the fact that all of us are raised to understand illness from nonprofessional perspectives (Chrisman and Johnson, 1996).

The DSM-IV-TR (American Psychiatric Association, 2000) recognised the potential for 'category fallacy' errors by cautioning the practitioner who is "unfamiliar with the

nuances of an individual's cultural frame of reference" that they "may incorrectly judge as psychopathology those normal variations in behaviour, belief, or experience that are particular to the individual's culture" (p. xxxiv). Practitioners are also warned in the DSM-IV-TR about attributing hallucinations and possession experiences to psychopathology, as these phenomena may be considered as normal in the person's cultural reference group. The DSM-IV-TR (American Psychiatric Association, 2000, p. 281) states: "Ideas that may appear to be delusional in one culture (e.g., sorcery and witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content may be a normal part of religious experience (e.g., seeing the Virgin Mary or hearing God's voice)".

When the service user's cultural or religious background is ignored or pathologised (Kilshaw, Ndegwa and Curran, 2002) category fallacy errors may occur. Or as Fernando (2002) succinctly puts it; what a practitioner "finds in a 'mental state' is as much a reflection of the observer as the so-called patient" (p. 117). Sanderson, Vandenberg and Paese (1999) reported on an experiment which highlighted the potential problem of category fallacy errors in the assessment process. In this study, fourteen mental health professionals were presented with a range of vignettes which described quasi-religious experiences, and were asked to indicate how authentic they thought these experiences were and whether they considered them to be pathological. The findings of this study revealed that those experiences that professionals considered to be more pathological were also judged by them to be less authentic. Furthermore, pathology was correlated with the experience being considered as unconventional by the professionals. Sanderson, Vandenberg and Paese argued that this showed that assessments were made primarily with reference to practitioners' own cultural norms, and thus, questioned the legitimacy of mental health assessment in a multicultural society.

Religion, Spirituality and Psychopathology: Matters of Diagnostic 'Concern'

Although psychiatric diagnoses are a medical responsibility, mental health nurses are actively involved in the assessment process by providing data and observational descriptions that inform psychiatric diagnoses (Crowe, 2006). Fallot (1998) notes that many practitioners want to know how to connect the religious and spiritual

concerns that are presented to them by service users in mental health settings with commonly used diagnostic categories. However, diagnostic criteria are not always helpful for practitioners attempting to assess the clinical significance of religious/spiritual phenomena. In such cases, the border between fantasy and reality is often elusive, especially when one is dealing with beliefs whose truth cannot be objectively corroborated (Koenig, 2007).

An effort was made by the 'culture task force' (Alarcon, 1995; Kleinman, 1996; Mezzich, Kleinman, Fabrega and Parron, 1996) for the DSM-IV (American Psychiatric Association, 1994) to incorporate information on cultural variations in symptomatology, although as Kirmayer, Young and Hayton (1997) noted, the basic structure of the diagnostic criteria remained largely unchanged. However, the DSM-IV's introduction of the 'V' (V.62.89) code, 'Religious or Spiritual Problem', in the section entitled 'Other Conditions That May Be a Focus of Clinical Attention', does offer practitioners the possibility that the religious or spiritual content of symptomatology is problematic and worthy of clinical attention, but is not attributable to a mental disorder (Lukoff, Lu and Turner, 1992; 1995; 1996; Lukoff, 2010; Lukoff, Lu and Yang, 2011). This includes distress related to "the loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values" (American Psychiatric Association, 1994, p. 685). After making the determination that the spiritual or religious problem is not attributable to a mental disorder, the 'V' code goes on to state that it is the practitioner's duty to decide whether or not the particular spiritual or religious concern warrants attention in the mental health setting (Fallot, 1998).

However, the 'V' code raises the problematic issue of where to place the boundaries between the functions of the religious and mental health professions, and how mental health practitioners can avoid the ethically and professionally dubious situation of offering opinions on religious or spiritual functioning (Loewenthal, 2007). It also is important for practitioners to realise that for many people with severe mental distress, "religious issues may be cause for distress but are not themselves expressions of a mental illness" (Fallot, 1998, p. 14). These include the variety of concerns that people without mental illness may have about religion (for example, how to deal with personal or family conflict about religion, or how to cope with

changes in spiritual convictions or practice). They also include concerns that medical anthropologists would place under the broad rubric of 'sickness'¹⁵(Hahn, 1995; Winkelman, 2009), such as the social stigma that is related to a person's mental health problem-for instance, being excluded or marginalised in faith communities, feeling shame about periods of religious disengagement, or having difficulties sorting through religious aspects of acute psychotic experiences (Fallot, 1998).

The inclusion of the 'V' code in the DSM-IV is, however, a significant improvement over previous editions of the DSM. In particular, the DSM-III-R (American Psychiatric Press, 1987) had simply associated all forms of religion or spirituality with signs of severe psychopathology (Post, 1992; Dein, 2000; 2004; 2010a; Bartocci and Dein, 2006; Vega, et al., 2006; Lukoff, 2010).The admission in the DSM-IV that judgements about psychotic illness must be tempered by the cultural context of religious practice is an acknowledgment of the entanglement of religious practices, cultural beliefs, and mental illness (Sanderson, Vandenberg and Paese, 1999). First, DSM-IV suggests that the evaluation of the clinical significance of religious phenomena cannot be separated from the cultural context of the person being assessed. It also highlights the clinical consequences of misdiagnosing religious practices and beliefs as evidence of psychosis (Fallot, 1998).

Furthermore, in 'Appendix 1' of DSM-IV, it is acknowledged that unique cultural patterns may account for specific beliefs and practices more accurately than generalised judgements based on 'universalised' psychiatric symptoms, drawing on several examples of religion's function as both explanatory framework and social structure. Many academics (e.g., Gabbard, Twenlow and Jones, 1982; Lovinger, 1984; Barnhouse, 1986; Alonso and Jeffrey, 1988; Greenberg and Witztum, 1991; 2001; Lukoff, Lu and Turner, 1992; 1995; Dein and Littlewood, 2007) have emphasised the importance of understanding the person's religious convictions and that of his or her religious community in order to make an adequate assessment of psychopathology. However, this can obviously pose problems where an idiosyncratic

¹⁵ The anthropological concept of 'sickness' refers to the social responses to distress and the social reality of distress (Hahn, 1995; Schulze and Angermeyer, 2003). 'Sickness' has been described as the totality of 'disease' and 'illness' (Young, 1982; Littlewood, 1989) and "occurs when the condition becomes known, recognised, interpreted and communicated into the world of meaning" (Loving, 2008, p. 15).

religious experience becomes the new norm for an emerging cultural group (Littlewood, 1983; Pierre, 2001).

The second implication is that the assessment of spiritual or religious phenomena must take into consideration the person's overall functioning (Greenberg and Witztum, 1991; 2001; Sims, 1992; 1994; Fallot, 1998; 2001; Peters, Joseph and Qarety, 1999; Clarke, 2001; Dein, 2010a; Kingdon, Siddie, Farooq and Rathod, 2010; Peters, 2010; Abdul-Hamid, 2011). For example, delusions of a religious nature may not necessarily be 'abnormal' in content (e.g., they may adhere to mainstream Christian doctrine and be based on the Bible), but rather, it is the fact that the person is entirely immersed in his or her religious pre-occupation (e.g., reading the Bible all day), the potential emotional and behavioural consequences of the beliefs (e.g., extreme distress if the closeness to God temporarily wanes), and self-neglect or complete passivity (e.g., in the face of God's omnipotence), which make the ideation pathological (Peters, 2010).

Perhaps, the most commonly cited way of differentiating religious phenomena from psychosis has been in terms of 'outcomes' (Dein, 2010b). Jackson and Fulford (1997) suggested that psychosis and spiritual experience could not be differentiated on the basis of form or content, rather the experience is considered non-pathological if it produces insight, is utilised to solve the initial problem, is life enhancing, and is generally adaptive. In contrast, psychosis is seen as detrimental to the life course. However, as Fernando (2002, p. 39) argues, a "person's level of fulfilment and identity, not just as an individual but also as a part of a group or society" can "be very different in different cultures". Thus, a person's functioning must be considered in its cultural context (Stolk, 2009). The primary source of problems in the assessment of religious phenomena, then, is the decontextualisation of these phenomena (Kilshaw, Ndewga and Curran, 2002).

There is of course the third implicit possibility of "not addressing spirituality because its expression is neither attributable to a mental disorder nor problematic enough to require clinical attention" (Fallot, 1998, p. 16). The assessment of spiritual and religious issues in DSM-IV is only considered in a problem focused way (Fallot, 1998). However, for many people with severe mental illnesses, spirituality and religion is more of a resource than a difficulty. A number of studies have supported

this conclusion (e.g., Lindgren and Coursey, 1995; Sullivan, 1998; Kirov, Kemp, Kirov and David, 1998; Tepper, Rogers, Coleman and Malony, 2001; Russinova, Wewiorski and Cash, 2002). In particular, a British study by Kirov, Kemp, Kirov and David (1998), assessed the importance of religious coping in 52 consecutively admitted psychotic patients and found that two thirds of these patients reported that they used religion to cope with their mental illness. As Fallot (1998) suggests, this recognition is significant because of the clinical bias that invariably assimilates the content of religious talk among people with mental illness to their psychopathology. Although there may be some reason for this attribution in the assessment of acute psychotic episodes, there is no compelling evidence that religion or spirituality per se is more problematic than any other domain of experience for people coping with mental illness (Fallot, 1998).

In fact, clinical reports have indicated that people who are not acutely psychotic may gain a great deal from the exploration of their religious or spiritual experiences (Kehoe, 1999). A more comprehensive assessment of a person's spirituality or religion is then required that moves beyond the mental disorder categorisation in the DSM-IV and which considers more holistically the place of spirituality or religion in the overall context and life of the person (Fallot, 1998). Despite this 'hard won' ground with the introduction of cultural factors into the DSM (American Psychiatric Association, 1994; 2000), research has revealed that there remains a major gap in the implementation of these factors in clinical practice. In particular, a survey (Stolk, 1996) of 88 clinicians in Melbourne, Australia, the majority of who were working in mental health crisis teams, found that just 10% of clinicians were aware of any of the cultural features identified in the DSM-IV.

The current edition of the 'ICD' (World Health Organization, 1992) did not include a similar 'V' code category. Abdul-Hamid (2011) argued that the inclusion of a 'Religious or Spiritual Problem' category in the 'ICD-10' may have provided practitioners with assistance in differential diagnosis. In ICD-10, the cultural context for diagnostic criteria is considered only in relation to the category of 'trance' and 'possession' disorders (Mitchell and Roberts, 2009). According to the ICD-10, these disorders are associated with a temporary loss of both the sense of personal identity and full awareness of one's surroundings. In some instances, the ICD-10 notes, the

person acts as if taken over by another personality, spirit, deity, or 'force'. However, this category only includes 'trance disorders' that are involuntary or unwanted, which intrude into ordinary activities, and occur outside religious or other culturally accepted situations.

'Normality' or 'Abnormality'

The boundary between 'culture' and 'psychopathology' relates to a wider question of substantive significance—the question of 'normality' (Helman, 2000; 2007). This is a topic of much controversy, even in the limited domain of psychiatry, quite apart from the arguments put forward by cultural relativists (Fernando, 1988; 2002; 2010; Dillard, et al., 1992; Bains, 2005). That is, what beliefs and behaviours can be considered as being 'normal' or 'abnormal'¹⁶, and by what criteria can they be judged (Offer and Sabshin, 1966; Tseng and McDermott, 1981; Grof and Grof, 1992; Prince, 1992; Hughes, 1996; Fitzgerald, et al., 1997a; Tseng, 1997; Swartz, 1998; Tseng and Streltzer, 2008; Stevenson, 2010)? Is mental illness universal and is there some universal standard by which to evaluate what psychiatrists have termed as mental illness (Fitzgerald, et al., 1997a)? Is it evenly distributed? Is there a temporal dimension to what is considered as 'abnormal' (Conrad and Schneider, 1980; Dein, 1997; Benatar, 2006)? Is there a range within which all societies set the boundaries of what can be considered as 'normal' (Brown, Gregg and Ballard, 1998)?

As Fitzgerald and colleagues (1997a) explained, such "questions go beyond whether or not a particular behaviour is evaluated as mental illness by the people involved, and ask if such behaviour is indicative of mental illness, no matter how it is judged or who does the judging" (p. 93). The search for an answer or solution to this dilemma has been one of the primary research concerns in the disciplinary fields that focus on transcultural mental health (Kleinman, 1977; 1980; Fabrega, 1989; Littlewood and Lipsedge, 1997; Fernando, 1988; 2002; 2003; 2010; Gaines, 1992; Swartz, 1998; Helman, 2000; 2007; Winkelman, 2009). It also presents itself as a dilemma for mental health practitioners at the level of 'clinical reality' (Kleinman, 1980; Good and

¹⁶ If behaviour is seen as 'abnormal' within a culture, but is seen as 'normal' by an outsider, it is called 'autopathological'. When behaviour is viewed as 'normal' within a culture, but is perceived by an outsider as 'abnormal', it is called 'heteropathological' (Tseng and McDermott, 1981).

Good, 1981; Gaines, 1982a; 1992). The 'culture' vs. 'nature' debate can be seen to have developed as a special instantiation of the Aristotelian polarisation between 'form' and 'matter' (Skultans and Cox, 2000). But whereas the significant partner in Aristotle's duality is 'form', their relative weighting has been reversed in contemporary debates about 'culture' and 'nature'. Clifford Geertz (1984, p. 272) famously suggested that there is a "tendency to see diversity as surface and universality as depth". Whatever relative weighting is given to 'culture' or 'nature', however-that is, whether one views oneself as a 'rationalist' or 'relativist'—"we cannot ignore the work of culture" (Skultans and Cox, 2000, p. 15).

Within the academic sphere of cultural psychiatry, three schools of thought have attempted to address the question about the 'universality' of mental illness: 'absolutism', 'universalism' and 'relativism' (Swartz, 1998; Fernando, 2002; 2010; Berry, Poortinga, Breugelmans and Chasiotis, 2011). These schools of thought have closely paralleled the development of the interpretive models used by anthropologists in their attempts to make sense of the apparent diversity of human societies (Fernando, 2002; 2010). Indeed, these fundamental questions cluster around a set of issues addressed in a famous collection of essays with the title 'Rationality and Relativism' (Hollis and Lukes, 1982); and these confront the anthropological discipline more forcefully than they do any other academic form of enquiry. They not only have important consequences for the nature and conduct of research enquiry (Kleinman, 1988a), but also have implications for how the issue of 'normative uncertainty' (Good and Good, 1986) is attended to in 'multicultural clinical interactions' (Fitzgerald, 1992).

'Absolutism' and 'Universalism'

The 'absolutist' school of thought perceives the 'form' and 'content' of psychological phenomena as basically the same across cultural contexts (Littlewood, 2000; Berry, Poortinga, Breugelmans and Chasiotis, 2011). Similarly, 'universalist' perspectives accept that there are cross-cultural similarities in the 'form' of psychological phenomena (Littlewood, 2000). However, within the 'universalist' position, there is an assumption that the 'content' of psychological phenomena is influenced by culture (Littlewood, 2000). That being said, this 'pathoplastic' (Argyle and Beit Hallahmi, 1975; Tseng, 1997) model of mental disorder has regarded the role of culture in the

shaping of distress as secondary at best (Jenkins and Barrett, 2003). ‘Absolutist’ and ‘universalist’ schools of thought use psychiatric diagnostic systems as the ‘standard’ and therefore, impose an ‘etic’ perspective on the observed phenomenon of interest (Swartz, 1998; Skultans and Cox, 2000).

The research literature indicates that both the ‘absolutist’ and ‘universalist’ positions have typically used four methods to differentiate between ‘normality’ and ‘abnormality’ (Offer and Sabshin, 1966; Tseng and McDermott, 1981; Fernando, 1988; 2010; Westermeyer, 1985; 1987; 1993; Hughes, 1996; Tseng, 1997; Swartz, 1998; Marsella and Yamada, 2007; Stevenson, 2010). Offer and Sabshin (1966) originally defined these four methods of differentiating between ‘normality’ and ‘abnormality’ respectively as, the ‘standard diagnostic method’ (‘normality as health’), the ‘psychoanalytic perspective’ (‘normality as utopia’), the ‘statistical approach’ (‘normality as average’), and by the ‘assessment of function’.

The ‘Standard Diagnostic Method’

‘Standard diagnostic’ methods are used by mental health practitioners to assess whether a person is ‘mentally ill’ (Offer and Sabshin, 1966). This approach is concerned with the “view that normality or pathology can be clearly differentiated by the nature of the phenomenon itself and the judgement can be made by trained professionals” (Tseng and Streltzer, 2008, p. 76). In its approach to diagnosis-classification of patterns of psychopathologic interest, it adopts the perspective of general medicine, formally labelled ‘nosology’, which has been characterised as an “eclectically assembled, chronologic polygot of different terms and ideas that reflect every layer of nosologic thinking from antiquity to the present” (Feinstein, 1977, p. 193). I have already outlined how this ontological approach to defining mental ‘abnormality’ is related to the ‘clinical reality’ of ‘disease’ (Eisenberg, 1977; Kleinman, 1980).

In the ideal biomedical diagnosis, it should be possible to gather a specific set of signs and symptoms, which are unequivocal indicators of an underlying pathology (Swartz, 1998). It is however, recognised in the major psychiatric diagnostic texts (e.g., ICD, DSM) that this ideal is in fact unattainable (World Health Organization, 1992; American Psychiatric Association, 1994). A ‘sign’ is defined as anything that

can be observed which indicates disease (Offer and Sabshin, 1966). For example, if a person talks to non-existent people, or claims to be hearing the voices of aliens, he or she will be considered as suffering from a mental condition that has a pathological basis based on such 'signs' (Tseng, 1997). A 'symptom' is what the patient complains of-tiredness, for example (Tseng, 1997). If 'abnormality' is identified, treatment consists of eradicating the signs and symptoms and hence, the underlying pathology (Offer and Sabshin, 1966).

A further feature of the 'standard' diagnostic method is that it is based on the 'Cartesian Dualism'-or the 'dogma of the ghost in the machine' (Ryle, 1949; Lock and Gordon, 1988; Good, 1994), asserting that the mind is separate from the body and "that there are mechanical causes of corporal movements and mental causes of corporal movements" (Fernando, 2002, p. 46). The 'standard' diagnostic method remains the dominant clinical approach in the 'professional' sector (Kleinman, 1978; 1980; 1984) of mental health services in the UK and other western countries (Fernando, 1988; 1998; 2002; 2003; 2009; 2010; Bhui, 2002; Sewell, 2009).

The 'Psychoanalytic' Model

The 'psychoanalytic' model and its decision-making about 'normality' and 'abnormality' are related closely to the 'standard diagnostic method' of biomedicine (Swartz, 1998). According to the psychoanalytic tradition, which originates from the work of Sigmund Freud (1991/1905), psychological signs and symptoms, as well as a variety of other non-pathological phenomena such as 'slips of the tongue', relate to underlying pathology of a psychological rather than a physical basis. In the psychoanalytical model, psychopathology is psychic in nature, but operates in a manner analogous to physical pathology, and treatment involves the eradication of the "underlying pathology" (Swartz, 1998, p. 54). While much has been written about the moral, philosophical and cultural underpinnings of the Freudian worldview, for the purposes of this background discussion it is enough to note the similarities in structure between the psychoanalytic system and the biomedical one. An important contribution of the psychoanalytic model, however, is that by insisting that there is a range of behaviours in the way that people conduct their lives, Freud (1991/1905) refused simply to label behaviour as 'abnormal'. He instead stressed the continuities

between 'normal' and 'abnormal' behaviour, by arguing that even people considered as functioning well live with pathological parts of themselves.

'Statistical' Approach

Freud's (1911/1905) idea that there exists a range of human behaviour relates well to the 'statistical' approach to defining 'abnormality' (Offer and Sabshin, 1966; Swartz, 1998; Rogers and Pilgrim, 2005). 'Abnormality' in the statistical approach is simply defined as "different from the norm or rule" (Swartz, 1998, p. 54). In the statistical approach, it can be specified how far from the average we want a characteristic to be before we label it as 'abnormal' (Offer and Sabshin, 1966). The concept of mean is universal, yet the range of mean often needs adjustment for different populations (Tseng, 1997). Theoretically at least, there is no value attached to the term 'abnormal' in the statistical model, as it simply means different from most other people and does not specify in which direction the difference occurs (Tseng and McDermott, 1981; Stevenson, 2010).

'Assessment of Function'

From a functional perspective, a person's behaviour is evaluated primarily by its impact on that person, other people, and the wider environment (Tseng, 1997; 2001; 2003; Tseng and Streltzer, 2008). So the criterion for judging 'normality' or 'abnormality' is not just "whether the condition provides (healthy) function or (unhealthy) dysfunction" (Tseng and Streltzer, 2008, p. 45) for the individual, but also the person's behaviour is evaluated for its perceived impact on the social context. For example, behaviour that is openly hostile and aggressive, that frequently disturbs one's family, neighbours, or wider society is normally considered as 'deviant' and sometimes as being 'pathological' (Tseng and McDermott, 1981; Helman, 2000; 2007). In contrast, what is considered as asocial and quiet behaviour may not be considered as 'dysfunctional' or labelled as 'pathological' if it does not cause any problems for other people and wider society (Tseng, 1997; Tseng and Streltzer, 2008).

The Multidisciplinary Mental Health Team and the Hegemony of the 'Standard Diagnostic Method'

An important clinical feature of the 'professional' sector (Kleinman, 1978; 1980; 1984) of the mental health services in the UK today, is the importance of the 'multidisciplinary' or 'mental health team' approach (Bonham, 2004; Clarke and Walsh, 2009). The mental health team, which typically comprises occupational therapists, social workers, mental health nurses, psychiatrists, and in some cases lay counsellors, may allow for different 'explanatory models' (Kleinman, 1980) of mental 'abnormality'. However, Fernando (2003) has argued that in most mental health settings in the UK, it is the biomedical model on which psychiatry is based that dominates; and it does so in two ways.

First, although various conceptual models of understanding mental distress are presented in the training of mental health practitioners other than psychiatrists (and even sometimes in the training of psychiatrists), the biomedical (biological) conception of mental illness, which conceptualises mental health problems as being caused by pathological lesions, is the base line or 'standard' for the assessment that is used (Fernando, 2003). Although pre-registered mental health student nurses typically explore psychological, social, cognitive, and biopsychosocial models of mental illness in their formal education at university, once they reach clinical placement, they are confronted with a biomedical dominance that is hard to challenge (Bassett and Baker, 2012). Second, when it comes to understanding 'clinical reality' (Kleinman, 1980; Good and Good, 1981; Gaines, 1982a; 1992) in mental health settings, the approach used by the psychiatrist typically overrides all the other disciplinary approaches, in part because of the power exercised (in)formally by psychiatrists in the current mental health system (Fernando, 2003). This is particularly the case for what Fernando (1998) has described as the 'hard end' of psychiatry, namely when compulsory powers are used to impose treatment and in forensic mental health settings. Thus although team members may well have experienced training approaches with very different emphases, the team as a whole will tend to work from the assumptions of the medical model where 'standard diagnostic methods' are paramount.

Evaluating 'Absolutism' and 'Universalism' from the 'Meaning Centred' Perspective

Offer and Sabshin's (1966) four approaches to defining 'normality' need to be seen in context-in their case, the context of the American way of life and worldview (Fernando, 2003). Once questions of culture are introduced one needs to look at the picture through the perspective of cultural 'norms'. In short we need to recognise that each culture has its own norms for health, for ideal states of mind, and for the functioning of individuals in society (Fernando, 2002; 2010). Clearly, 'absolutist' and 'universalist' approaches do not give equal weight and value to ways of seeing the world that depart from the 'etic' oriented 'standard' diagnostic method and its affiliated perspectives (Andary, Stolk and Klimidis, 2003; Stolk, 2009). That is, they do not give careful attention to the notion that one's way of seeing the world shapes how one sees the world (Swartz, 1998).

A further feature of these approaches is that they tend to look at mental disorders as existing 'out there' waiting to be discovered (White and Marsella, 1982; Kleinman, 1988a). Viewing mental disorders "as a thing is an example of what is known as reification-a process of viewing" phenomena as "fixed and static entities" (Swartz, 1998, p. 13). However, in keeping with the 'meaning centred' approach of this research study, the definition of 'abnormality' in absolutist and universalist approaches is an interpretation of someone's experience from the 'clinical reality' of 'disease' (Eisenberg, 1977; Kleinman, 1980; Good and Good, 1981; Gaines, 1982a; 1992; Good, 1994).

In the previous chapter I alluded to how absolutist and universalistic approaches have in common two primary features. First, they are based on an 'individualistic' (Gaines, 1982b; White and Marsella, 1982; Shweder and Bourne, 1982; 1984) conception of the self, which does not make reference to spiritual or supernatural causation of illness (Seeley, 2006). Second, on the surface they do not make moral judgements about 'abnormality' (Kleinman, 1988b; Shweder, 1991; Fitzgerald, et al., 1997a; Swartz, 1998). As we have seen, mental abnormality is viewed as a medical or psychological problem, or 'statistical', or 'functional' deviation from the 'norm' (Offer and Sabshin, 1966)-and the scientific method adopted by these approaches emphasises rationality and a dispassionate perspective rather than a moralistic one (Swartz, 1998).

Cultural Relativist Perspectives

Drawing their inspiration from Wittgenstein's (Kishik, 2008) notion of 'forms of life', relativists are concerned less with the physical aetiology of distress than with the psychological, behavioural, and socio-cultural dimensions associated with them (Prince, 1992; Prince, Okpaku and Merkel, 1998). Medical anthropology's emphasis on cultural relativism also has different implications for the question of 'normality' and 'abnormality', and, at the level of 'clinical reality' (Kleinman, 1980; Good and Good, 1981; Gaines, 1982a; 1992), for the issue of 'normative uncertainty' (Good and Good, 1986). From a cultural relativist perspective, it is obvious that different cultures have different ideas about 'abnormality', but "it is less obvious how such abnormality is defined and recognised" (Littlewood and Lipsedge, 1997, p. 189). This may lead to uncertainty for mental health practitioners in clinical practice.

The relativist perspective has weak and strong forms (Prince, Okpaku and Merkel, 1998). While not denying the role of physical factors in the aetiology of severe mental illness, weak forms of the relativist perspective hold the view that what is 'normal' is culturally defined and can only be understood properly when considered within its cultural context (Winkelman, 2009). The strong form of cultural relativism considers that what is experienced as distress in each cultural system is so unique that it is impossible to make any valid cross-cultural comparisons (Gaines, 1992). In the context of this background discussion, the important point to make is that regardless of whether a weak or strong form of cultural relativism is adopted, "the question of what is normal versus what is abnormal can be appropriately determined only in the context of a person's cultural expectations, beliefs, and situation" (Winkelman, 2009, p. 208). Thus relativists incorporate the worldviews of the people being studied or treated, and therefore adopt an 'emic' approach to understanding distress (Castillo, 1997a; b; c; Brown, Gregg and Ballard, 1998; Cockerham, 2000).

At the same time the incorporation of a culturally relativist perspective into clinical practice raises concerns and questions. Who "determines whether or not the experience is culturally congruent? What criteria should be used in making the determination? What aspects or dimensions of the experience are important in these kinds of decisions" (Sanderson, Vandenberg and Paese, 1999, p. 608)? The 'sharedness' of beliefs, experiences, and behaviours alone may not be a sufficient

criterion for making a distinction between culture and psychopathology, since the sharing of beliefs, experiences, and behaviours does not exclude the possibility that they are pathological (Gaines, 1988; 1995; Pierre, 2001). An alternative criterion may need to be proposed, such as the extent of 'sharedness' or 'reasonableness' in terms of the culture at large (Gaines, 1988; 1995).

Moreover, a person's spiritual or religious experiences do not necessarily indicate psychopathology, even if they are considered as atypical within their cultural context (Johnson and Friedman, 2008). For example, it is generally not perceived as 'normal' within some cultural contexts to have directly heard the voice of God or to have communed with spiritual entities. Yet many people who are not actively affiliated with any religious or spiritual movement that may endorse these types of experiences claim to have had similar experiences (Romme and Escher, 1989; Tien, 1991; Grof and Grof, 1992; Bragdon, 1993; Hood, Spilka, Hunsberger and Gorsuch, 1996; Poulton, et al., 2000; Tobert, 2007; 2010). Argyle (2000) has reported that around one third of the population in Britain, Australia, and the US has had some kind of spiritual experience. Although these experiences may appear to be incongruent with the expectations of one's cultural reference group, they do not necessarily signify psychopathology, the determination of which invariably depends on the worldview of the mental health practitioner, and his or her openness to non-pathological altered states of consciousness (Tobert, 2007; 2010; Johnson and Friedman, 2008).

Summary

At the core of this review discussion is the major controversy that has divided medical anthropologists and scholars from the health sciences, namely the concept of cultural relativism and its implications for the assessment and treatment of psychological 'abnormality'. As Hughes (1996, p. 137) has suggested, "the clear specification of when a pattern of norm-violating behaviour passes from being an instance of mere chicanery or criminality to that of pathology is one of the most vexing issues in the fields of psychiatry and social deviance". Whether we approach the phenomenon of distress from an 'absolutist', 'universalist', or 'relativist' school of thought will influence how culture is attended to in the evaluation, assessment, and treatment of psychopathology. 'Absolutist' and 'universalist' perspectives approach the issue of 'normality' and 'abnormality' from an ontological position of biological

primacy, so that the cultural context for a service user's distress is irrelevant to the assessment process or only shapes the content of the disorder (Argyle and Beit Hallahmi, 1975; Tseng, 1997). By contrast, 'cultural relativist' schools of thought approach the problematic issue of 'normative uncertainty' (Good and Good, 1986) with regard also for the 'emic' perspective of the service user and their wider social circle.

Fernando (2002; 2010) and Stevenson (2010) have argued that on their own, neither the absolutist/universalist nor cultural relativist approaches offer reliable guides for identifying 'abnormality'. After all, they argue, it is perfectly feasible to behave in a way that is determined as being 'statistically unusual', 'dysfunctional', or 'culturally inappropriate' without requiring medical treatment. Fernando (2002; 2010) suggests that absolutist/universalist and cultural relativist perspectives are inadequate for two primary reasons. Firstly, biological, social, and psychological factors all influence the nature of what emerges as a 'distress' in a given cultural setting. The social construction of illness within a cultural setting, such as its norms for health, functioning of individuals in society, and ideal states of mind are important, but are not the only considerations. Secondly, cultures are not distinct and unchanging entities, as there is always a constant interchange between cultures, although powerful forces may impact on the nature of these changes (also see Watters, 2011). As Skultans and Cox (2000, p. 15) noted, "the true value of this debate lies not in deciding whether culture or nature has more depth but rather in sensitizing medical anthropologists and cross-cultural psychologists to the ubiquity of culture". No professional consensus has emerged to guide mental health practitioners in the sensitive area of 'normative uncertainty' (Good and Good, 1986). In fact, the advice that is given is often confusing and contradictory, thus exacerbating practitioners' uncertainty. As Neeleman and King (1993) and Stolk (2009) more recently suggested, the absence of guidelines may give rise to idiosyncratic practice, inadequate concepts of religion, spirituality, and their relevance to all aspects of the clinical process; and potentially to the outright dismissal of service users' religious or spiritual beliefs, experiences, and practices.

Chapter 4

Methodology

Introduction

The focus of this study was to explore the primary cultural issues and the responses to these issues in pre-registered mental health students nurses' clinical placements. An anthropologically informed research design (Sobo, 2009) grounded the exploration of these issues and responses. Given the complexity of student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992), the nature of the research questions, the anthropologically informed research design, and the meaning centred perspective (Good and Good, 1981; Gaines, 1982a; Good, 1994), a qualitative strategy was clearly indicated and applied.

Stories or narratives are integral to culture (Kleinman, 1988b; Mattingly, 1998a; b) and they are the mainstay of what anthropologically informed research collects and analyses (Sobo, 2009). Alongside this global orientation to narrative construction, the storied accounts of the student nurses and nursing educator participants were based on 'critical incidents' (Fitzgerald, 2000). A description of the 'critical incident' approach and its application to the study is outlined in this chapter. Although critical incidents can be generated by various qualitative methods, the 'critical incident' (Fitzgerald, 2000) focused ethnographic interview (Spradley, 1979) was the method chosen for this study. This approach to generating critical incident narratives is concerned with eliciting meanings ascribed to specific experiences and events through guided reflection (Fitzgerald, et al., 1997a). It also aids in uncovering the tacit dimensions of clinical practice, generates 'thick descriptions' (Geertz, 1973), and is concerned with understanding and meaning in context (Laws and Fitzgerald, 1997; Odawara, 2005; McAllister, et al., 2006). It therefore was congruent with the anthropologically informed research design.

The critical incident approach has been used successfully across a number of professional fields in the health and nursing sciences. However, it is in the study of intercultural or 'multicultural clinical interactions' (Arthur, 2001; 2004; Fortune, 2002; Kilshaw, Ndegwa and Curran, 2002; Whiteford and McAllister, 2006; McAllister, et

al., 2006; McAllister and Whiteford, 2008) that the approach has shown particular utility. Thus, the 'dependability' (Lincoln and Guba, 1985) of the findings was enhanced by following recognised and relevant procedures of data collection. The discussion in this chapter then moves on to detailing the method. A 'thick description' (Geertz, 1973) is given of the access arrangements, ethical protocols, recruitment of participants, the characteristics of participants, data collection, and member checking strategies. Underpinned by a constructivist approach (Lincoln and Guba, 1985), thematic analysis was applied to the corpus of data and the resultant themes and categories emerged through the 'constant comparative process' (Glaser and Strauss, 1967).

An Anthropologically Informed Research Design

An anthropologically informed research design provided the overall methodological framework for this investigation. The medical anthropologist and health services researcher Elisa Sobo (2009) outlined the fundamental aspects of an anthropologically informed research design in her recent text 'Culture and Meaning in Health Services Research: A Practical Field Guide'. In this text, Sobo (2009) recognised the practical limitations on full immersion in clinical settings and defined an anthropologically informed approach as "ethnographic in aim, even when contingencies mean that it cannot be truly ethnographic in scope (i.e., when immersion cannot happen)" (p. 77). As Sobo (2009, p. 76) notes, "most HSR (Health Services Research) cannot qualify as ethnography per se, simply because of the nature of what the communities under study are engaged in and the necessity for researchers to respect their workplace, health and rehabilitation, and sickroom and deathbed needs". Like ethnographic research, an anthropologically informed approach places priority "on holism and a systems perspective that favours emic points of view, achieves critical distance, and takes a reflexive stance toward the research context" (Sobo, 2009, p. 77). Anthropologically informed research subsumes an ethnographic epistemology-even though it does not entail the fully-fledged ethnographic research process. Although this PhD study was not traditionally ethnographic, it "was anthropologically informed; anthropology's 'signature' was valid" (Sobo, 2009, p. 76).

An anthropologically informed design underpinned this study, as ethical and access contingencies meant that immersion in and observation of student nurses' 'multicultural clinical interactions' (Fitzgerald, 1992) was not feasible. In terms of ethical contingencies, there was the concern that observing student nurses in clinical situ would increase the level of anxiety for the students and alter their clinical placement experience. Gaining consent and access to carry out ethnographic research in clinical placement settings would have been difficult, and observation of student nurses' clinical interactions could have added to the distress of service users. The level of anxiety for both student nurses and service users is likely to be heightened in mental health care settings. Indeed, the student nurses' own 'critical incident' (Fitzgerald, 2000) accounts collected for this study, conveyed the everyday stresses of working in such pressured, and in many cases, distressing conditions. When considering the lack of power in certain occupational groups-such as junior healthcare staff (e.g., student nurses), these challenging ethical questions may be heightened (Savage, 2000). Similar concerns have been raised by Spence (1999) in her hermeneutical research on the experiences of New Zealand based nurses caring for culturally diverse service users. At the same time, the lack of opportunity to observe the actual practices of student nurses in 'multicultural clinical interactions' was a limitation of this study. As Lambert and Mckevitt (2002, p. 211) explain; "what people (including health professionals) say can be different from what they think and do". Clinical interactions are shaped by contingent circumstances and forms of practical reasoning that are not always expressed orally in interview type situations.

This project was anthropologically informed in other important respects. The student nurses' 'multicultural clinical interactions' were contextualised in the wider 'health care system' (Kleinman, 1978; 1980; 1984) and the fluid culture of mental health nursing (Suominen, Kovasin and Ketola, 1997). Thus, the study was holistic and systems focused. The perspectives of the participants' were prioritised by using methods that evaded, as far as was possible, the unnecessary imposition of researcher-driven categories on the data collection and analytical processes. As I will discuss in the following sections of this chapter, the primary method of this study drew upon 'critical incident' (Fitzgerald, 2000) focused ethnographic interviews (Spradley, 1979). 'Critical incidents' are a subset of the narrative technique (Fitzgerald, 2001) that is often used in anthropologically informed and ethnographic

health services research. The 'critical incident' focused ethnographic interview, "generates 'thick' description, uncovers tacit dimensions of practice and generates whole chunks of data" (McAllister, et al., p. 371-372). This approach also minimises the social response bias that may occur when discussing issues of research interest in general terms (Laws and Fitzgerald, 1997), and allows for the understanding of meaning in context (McAllister, et al., 2006). Furthermore, the analytical categories which emerged from this study were grounded in the data-an analytical process known as 'inductive category development' (Lincoln and Guba, 1985).

By taking a critically applied medical anthropological position (Shaw, 2005), critical distance (Browner, 1999) was attained in this PhD study. According to Sobo (2009), critical distance "entails the ability to question categories from an outside or detached perspective" (p. 72) and promotes an awareness of their socially and culturally constructed dimensions. This study critically examined the student nurses' frames of reference (Tebbutt and Wade, 1985), the culture of mental health nursing, and the clinical placement settings in which the students were situated. Thus, I sought to escape the critical conundrum posed by the unnecessary opposition between 'applied' and 'theoretical' medical anthropology¹⁷ (Shaw, 2005; Hahn and Inhorn, 2009). My non-clinical background also meant that technically I was an outsider, and by this very status, I could maintain a critical distance. A reflexive stance was taken to the research context and to decisions about methodology, data collection, and the analytical process. As such, I have striven to present the methodological process in enough detail-so that others are able to arrive at similar conclusions.

¹⁷ While scholars and practitioners in the health and nursing sciences (e.g., Kim, 1991; Brach and Fraser, 2002; Betancourt, 2004; Papadopoulos, Tilki and Lees, 2004) have shown a keen interest in the concept of 'culturally competent' health care (there are literally thousands of academic articles), the engagement of medical anthropologists (with important exceptions) has been less notable (Stone, 1992; Santiago-Irizarry, 1996; 2001; Lambert and Sevak, 1996; Laws and Fitzgerald, 1997; Fitzgerald, Clemson and Mullavey-O'Byrne, 1997; 2001; Fitzgerald, et al., 1997a; Hunt, 2001; 2005; Bonder, Martin and Miracle, 2001; 2002; 2004; Wayland and Crowder, 2002; Briggs, 2003; Taylor, 2003a; b; 2010; Manderson and Allotey, 2003; Sobo and Seid, 2003; Sobo, 2004; 2009; Fox, 2005; Hudelson, 2005; 2006; Hunt and DeVoogd, 2005; Shaw, 2005; Dein, 2006; Kleinman and Benson, 2006; Galanti, 2008; Sobo and Loustanaunau, 2010; Willen, Bullon and Good, 2010; Good, et al., 2011). Shaw (2005) notes two broad medical anthropological approaches to the issue of cultural competence-those who seek to modify clinical practice and attempt to make it more culturally appropriate, and those who critique the models of culture and identity mobilised in such programs.

The methodological perspective of this PhD study also shared some characteristics with 'focused clinical ethnography' (Leininger, 1985; Kleinman, 1992; Muecke, 1994; Morse and Field, 1995; Roper and Shapira, 2000; Germain, 2001). Like focused ethnography, this study defined the notion of 'key informants' (nursing educators), as persons with a store of knowledge and experiences to share, relative to the phenomenon of inquiry (Roper and Shapira, 2000). This notion of 'key informant' is different to how the concept is interpreted in traditional ethnography, where the ethnographer has the opportunity to develop close relationships with their informants over time (Emerson, 1983). Like focused ethnography, this study was concerned with a delineated form of inquiry and with a relatively narrow band in the cultural spectrum of local worlds (Leininger, 1985). The cultural phenomena relevant to this study arose out of specific 'cultural scenes' (Spradley and McCurdy, 1972), 'social dramas' (Turner, 1974), and 'critical incidents' (Fitzgerald, 2000), which were drawn from accounts of 'multicultural clinical interactions' in placement settings.

A Qualitative Strategy

Given that the study was concerned with exploring the meaning of pre-registered mental health student nurses' 'multicultural clinical interactions', a qualitative strategy was used (Good, 1992; Cresswell, 1994; Whiteford and Wright St-Clair, 2002; Flick, 2008a). This qualitative strategy is explicated in more detail over the following sections of this chapter. Particular emphasis is given to the value of exploring student nurses' 'multicultural clinical interactions' through the storied nature of experience, or more specifically, by the elicitation of 'critical incident' narratives (Fitzgerald, 2000). Stories are integral to culture and anthropologically informed research (Sobo, 2009), and qualitative data can help the researcher get a feel for the story line-that is, for the meaning that motivates people towards action or inaction as the case may be. The meaningful assessment of participants' 'critical incident' narratives by the open-ended process of ethnographic interviewing (Spradley, 1979) was considered as the most suitable method in this research context.

The Meaning of 'Critical Incidents': Contextualising the Narratives of Student Nurses' 'Multicultural Clinical Interactions'

'Critical incidents' (Fitzgerald, 2000) were central to the methodological foundations of this research project, as they were the basis of the narratives that participants shared with me during the ethnographic interviews (Spradley, 1979). However, one has to be clear about the context in which the term 'critical incident' is used, as it is a fuzzy concept with multiple and contrastive meanings (see, Flanagan, 1954; Fitzgerald, 2000; Cortazzi, 2001; Turunen, 2002; Chell, 2003; Turunen, Tossavainen and Verlio, 2004; Mikkonen, 2005). In historical studies, the term 'critical incident' (Tripp, 1993) has referred to some event or situation that marked a significant turning point or change for a person, institution, or social phenomenon. Similarly, in the health sciences, this term is synonymous with experiences that are drawn from unintended consequences; and a negative outcome usually defines whether something is viewed as 'critical' or not (Hunter, Spence and Scheinberg, 2008). Moreover, in biomedicine, the term has implied legal connotations (Hunter, Spence and Scheinberg, 2008), as in a case of clinical negligence, which could have, or did, lead to unintended harm to a person (e.g., patient); or a situation which has or is likely to occur in the context of 'critical care'¹⁸ (Reed, 1994); or a 'trouble case' example-such as when a clinician and patient disagree over what is considered to be acceptable standards of behaviour (Kaufert, Kilage and Kaufert, 1984).

Other concepts have also been used as synonyms for the term 'critical incident', and these concepts seem to denote a more positive meaning (Turunen, 2002). In the psychological literature, 'authentic experience' (Rahilly, 1993), 'symbolic growth experience' (Frick, 1987; 1990), and 'significant life experience' (Merriam and Clark, 1993) have been used as synonyms for critical incidents. These synonyms for critical incidents all appear to describe the transformative effects of such significant events (Edwards and Fitzgerald, 2001). Furthermore, Brim and Ryff's (1980) concept of 'life event' refers to a situation that is assigned properties in terms of the informant's perception of the event. The purpose of eliciting a 'life event' is to gain an understanding of the subjective nature of meaningful experience.

In the context of student nurses' and their nursing educators' recollections of 'multicultural clinical interactions' (Fitzgerald, 1992) in placement settings, it was

¹⁸ 'Critical care' (Reed, 1994) is a phrase often applied in nursing practice and is used to define the types of work that goes on in 'Accident and Emergency' (A&E) and 'Intensive Therapy Units' (ITU).

more helpful to draw on Fitzgerald's (2000) adaptation of Brislin and colleagues' (Brislin, 1981; 1990; 2000; Brislin, Cushner, Cherrie and Yong, 1986; Brislin and Yoshida, 1994) definition of 'critical incident'. In particular, Fitzgerald (2000, p. 190) defined 'critical incidents' as "distinct occurrences or events which involve two or more people; they are neither inherently negative nor positive, they are merely distinct occurrences or events which require some attention, action or explanation; they are situations for which there is a need to attach meaning". Like ethnography (Fitzgerald, 1997), critical incidents can be viewed as both 'product' and 'process'. A critical incident is a 'product'-in the sense that it is recorded output, which has a particular construction and is available to a wider audience, as a tool for critical analysis and further study (Fitzgerald and Mullavey-O'Byrne, 1998). As I describe in the recommendations (conclusion chapter) section of this thesis, critical incidents can be used as educational tools to assist future undergraduate mental health student nurses in understanding cultural and mental health issues, and applying clinically relevant anthropological concepts. At the same time, a critical incident is a 'process' and an interactive event, as there is a social exchange of meanings in a particular context (Fitzgerald and Mullavey-O'Byrne, 1996; Fitzgerald, Williamson and Mullavey-O'Byrne, 1998). As a 'process', a critical incident is a symbolic representation of a 'multicultural clinical interaction'. The critical incident engages our attention, arouses our curiosity, and requires some explanation if we are to attach meaning to the interactive event (Fitzgerald, 2001).

Critical incidents also can be viewed as 'social dramas', or as "units of aharmonic or disharmonic process" (Turner, 1974, p. 37). Like 'social dramas', Sue and Sue (1990, p. 245) suggest that critical incidents represent a "*conflict* of cultures, values, standards, or goals", but according to Fitzgerald (2000, p. 190), they "do not necessarily arise out of conflict situations". Such 'conflict' usually results in 'disconfirmed expectancies' (Mullavey-O'Byrne, 1994a, b; 1999; Fitzgerald and Mullavey-O'Byrne, 1994; 1995; 1996; 1998; Mullavey-O'Byrne and Fitzgerald, 1995; Mullavey-O'Byrne and West, 2001), where the 'multicultural clinical interaction' (Fitzgerald, 1992), 'event' (Cortazzi, 2001), 'cultural scene' (Spradley and McCurdy, 1972), or 'social drama' (Turner, 1974):

"Did not play out in quite the way the respondent or narrator anticipated. It may have had a result viewed as negative-one that may have evoked a disquieting state of

emotional arousal (e.g., frustration, anxiety, a sense of having lost control). However, just as often the result was viewed as positive in that there was a better than expected result. In both cases there is a need for explanation, a need to attach meaning”.

(Fitzgerald, 2000, p. 190)

‘Disconfirmed expectancies’ may lead to a sense of ‘cultural dissonance’ and an inability to deconstruct the interaction in a way that leads to satisfying solutions and strategies for care (Fitzgerald and Paterson, 1995; Mullavey-O’Byrne and West, 2001).

‘Critical incidents’ are a subset of the narrative technique (Aranda and Street, 2001; McCance, McKenna and Boore, 2001; Schaefer, 2002), which has often been used in ethnographic and anthropologically informed health services research (Fortune, 2002; Lovering, 2008; Yule, 2008). It is based upon the idea that we communicate, problem solve, understand, relive, and try to give meaning and coherence to distinctive events through narratives and story making (Kleinman, 1988b; Bruner, 1990; Fitzgerald, et al., 1997b; Mattingly, 1998a; b; Russell, et al., 2002). The value of accessing the storied nature of experience has been developed by the efforts of Ricouer (1985), Bruner (1990), Riessman (1993), and Kleinman (1988b) among others. According to Kleinman (1988b, p. 49), narratives “shape and even create experience” and the “plot lines, core metaphors, and rhetorical devices that structure...narrative are drawn from cultural and personal models for arranging in meaningful ways and for effectively communicating those meanings”. Thus, narratives communicate cultural understandings within a specific context and link culture, meaning, and experience (Campbell, 2000; Fitzgerald, 2000). Narratives have additional distinct features, the primary ones being universality, sequentiality, and intentionality (Wicks and Whiteford, 2003).

However, while a conventional narrative has a resolution or endpoint, a critical incident is typically a story with an issue to be resolved, or the resolution is less than satisfactory and not well understood (Fitzgerald, 1996; 1997; McAllister, et al., 2006). As a result, the incident is open to alternative explanations and interpretations (Fitzgerald, 2001). While clinical case studies invariably contain pieces of decontextualised information, critical incidents are more reflective of what happens in

the process of clinical interactions (Armstrong and Fitzgerald, 1996; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Edwards and Fitzgerald, 2001; Clemson, Fitzgerald and Mullavey-O'Byrne, 2001; Fitzgerald, Williamson, Russell and Manor, 2005). The major features of critical incidents involve an event structure (which reports happenings), a description structure (background information necessary to understand the incident-time, place and people involved) and an evaluation structure (which presents the narrator's perspective on the events-their meaning, relevance and importance) (Cortazzi, 2001).

The Generation of 'Critical Incident' Data: Considering the Alternatives

Introduction

Having set out its meaning and definition, it is important now to consider the relevancy of the 'critical incident' approach (Fitzgerald, 2000) to the research at hand. As Sandelowski (2000, p. 335) has observed, no method is "absolutely weak or strong, but rather more or less useful or appropriate in relation to certain purposes". Given its specific narrative orientation (Fitzgerald, 2000); its congruence with an anthropologically informed (Sobo, 2009) research design; its concern with eliciting meanings ascribed to specific experiences and events through guided reflection (Fitzgerald, et al., 1997a); the focus on the immediacy of experience (Fitzgerald, 2001); the generation of 'thick descriptions' (Geertz, 1973); the uncovering of tacit dimensions of clinical practice (Laws and Fitzgerald, 1997); its concern with understanding and meaning in context (Odawara, 2005; McAllister, et al., 2006); the complexity of 'multicultural clinical interactions' (Fitzgerald, 1992); and the paucity of research in the area; the 'critical incident' focused (Fitzgerald, 2000) ethnographic interview (Spradley, 1979) approach was adopted in this study. Before I discuss these strengths and the relevance of the 'critical incident' focused ethnographic interview approach in more detail, I will review the other commonly cited methods for generating critical incident data. However, I will firstly provide a brief description of how the critical incident approach has been applied to topics of interest in the health sciences.

The 'Critical Incident' Approach and the Health Sciences

The 'critical incident' approach was first popularised by the aviation psychologist John Flanagan¹⁹ (1954), but has since been adapted and used successfully across a number of professional fields in the health sciences. From the 1960s onwards, the approach has made its most profound impact on nursing research and education (Cormack, 1983; 1996; Benner, 1984). According to Narayanasamy and Owens (2001), this approach brings credence to nurses' practice, because it is largely concerned with the real rather than the abstract world and acknowledges the constraints that nurses' encounter in their work.

The sheer diversity of nursing related topics to which the approach has been applied and the variety of qualitative methods used to collect 'critical incident' data demonstrates the versatility of this inductive approach to data generation (Dachelet, et al., 1981; Norman, Redfern, Tomalin and Oliver, 1992; Byrne, 2001). In particular, the approach has been used effectively in the study of nurses' interpersonal communication skills (Clamp, Gough and Land, 2004); community psychiatric nurses' use of humour during interactions with service users (Struthers, 1999); dealing with aggressive ward visitors (Laight, 1995); emergency nursing (Burns and Harm, 1993; Wahlin, Wieslander and Fridlund, 1995); oncology care (Cohen and Sarter, 1992); nurses' responses to the spiritual needs of their patients (Narayanasamy and Owens, 2001); language awareness (Irvine, et al., 2008); rehabilitation care (Rimon, 1979); how nurses' emotions affect patient care (Gow, 1982); assessing nurses' competency and expertise (Benner, 1984); exploring the function of the psychiatric nurse (Cormack, 1983); standards of care (Grant and Hryciuk, 1985; Cox, Bergen and Norman, 1993; Beech and Norman, 1995; Grant, Kreimer and Bannatyne, 1996; Kemppainen, 2000); treatment of older people (Reed, 1994); and community nursing care (Malin, 2000).

More importantly, the critical incident approach has shown real utility in the study of intercultural or 'multicultural clinical interactions' (Arthur, 2001; 2004; Fortune, 2002; Kilshaw, Ndegwa and Curran, 2002; Whiteford and McAllister, 2006; McAllister, et

¹⁹ The 'critical incident technique' (CIT) has been developed for a wide range of specific purposes by business, industry, organisational psychologists, and other professional groups. Safety checklists, guidelines for action in emergency situations, and the establishment of occupational performance criteria are examples of the applied outcomes of this approach (Burgoyne and Hodgson, 1983; Bygrave, 1989; Chell, 2003).

al., 2006; Lovering, 2008; Yule, 2008; McAllister and Whiteford, 2008). It is the work of the medical anthropologist Maureen Fitzgerald and colleagues' at the 'Intercultural Interaction Project'²⁰ in the 'School of Occupational Therapy' at The University Of Sydney (Mullavey-O'Byrne, 1994a;b; Fitzgerald and Mullavey-O'Byrne, 1995; 1996; 1998; Fitzgerald and Paterson, 1995; Mullavey-O'Byrne and Fitzgerald, 1995; Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, 1996; 2000; 2001; 2004; Fitzgerald, et al., 1996; 1997a; 1997b; Laws and Fitzgerald, 1997; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; 2001; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997; Fitzgerald, Robison, Clemson and Mullavey-O'Byrne, 1997; Fitzgerald, Williamson and Mullavey-O'Byrne, 1998; Clemson, Fitzgerald and Mullavey-O'Byrne, 1999; Edwards and Fitzgerald, 2001; Mullavey-O'Byrne and West, 2001; Russell, et al., 2002; Fitzgerald, Williamson, Russell and Manor, 2005) however, who have most significantly advanced understandings of the particular saliency of the critical incident approach to researching clinical interactions and intercultural learning processes. Thus, the 'dependability' (Lincoln and Guba, 1985) of the PhD study findings was enhanced by following a recognised approach to data collection.

Collecting 'Critical Incidents'

'Critical incidents' can be collected in situ or retrospectively, or by using a combination of these approaches (Clamp, 1980; Burgoyne and Hodgson, 1983; Brookfield, 1987; 1990; 1992; 1993; Callery and Smith, 1991; Cormack, 1993). When used within an ethnographic approach, critical incidents can be derived from participant observation by giving meaning to the interpretation of naturally occurring events (Fitzgerald, 1997). In doing so, many forms of data are drawn on by the ethnographer to make sense of what they see and experience (Fitzgerald, Paterson and Azzopardi, 1997). Given the aforementioned problems with gaining access to mental healthcare settings in the UK, it was not practical or feasible to use this approach. In regard to the methodological contingencies with using this approach, it would have been difficult for a third person to remain unobtrusive while collecting

²⁰ The 'Intercultural Interaction Project', which began in 1992, was developed to: 1) Research culture and communication issues in clinical care and 2) provide occupational therapy students with an opportunity to use the research process to develop cultural knowledge and communication skills that would be useful to them in clinical practice (Fitzgerald, et al., 1997a).

critical incident data during student nurses' 'multicultural clinical interactions'. Rimon (1979) has suggested that it is likely that an outsider "would not only prove to be annoying to the staff and patients while attempting to do this (collect critical incidents), but also would preclude the spontaneous occurrence of many of the incidents, which so depend on a confidential and private atmosphere for the nurse and patient" (p. 406). Thus, retrospective methods are usually preferred by researchers.

An added advantage of the retrospective elicitation of critical incidents is its focus on the description of actual events rather than the description of things as they should be (Hasselkus and Dickie, 1988). The retrospective reporting of incidents in this PhD study helped the participants to describe incidents that occurred in their recent or less recent past; and therefore the long and short term experience that shapes mental health nursing was brought up in the interview sessions (Cormack, 1996). Indeed, the longer term consequences of student nurses' clinical interactions became clear, as some of the participants described the development of therapeutic relationships with service users over a period of many weeks.

However, the literature highlights some limitations of collecting critical incidents retrospectively. The problem of 'hindsight bias' (Cope and Watts, 2000) is frequently mentioned in this research literature-although Chell (2003) argues that the participant usually has good recall, as by their very nature, these type of accounts are 'critical'. Fitzgerald and colleagues' (1997a) research for the 'Intercultural Interaction Project' found that even when more current critical incidents could have been talked about, many of their participants still talked about incidents from past clinical encounters. These past encounters remained as 'critical incidents' for these participants, as they were 'social dramas' (Turner, 1974) that were not satisfactorily resolved in their minds and thus, still needed working through. In the context of this PhD study (with the exception of one case), the participants had no problem with recalling critical incidents from mental health student nurses' clinical placements.

A commonly cited retrospective method of eliciting critical incidents is by their written generation (Martin and Mitchell, 2001). Rosenal (1995) suggests that this method reveals the experience of the nurse who writes them. With this particular method, a set of instructions is given about what kind of incident should be identified and the

author of the incident is then instructed to detail the context in which the incident occurred, why it made a significant impression on them, and what they remembered feeling or thinking at the time (Smith and Russell, 1993; Smith, 1998). The written generation of incidents has been described as an efficient process, saving the researcher valuable time that would be expended in an interview situation (Brookfield, 1987). This method has also been used in studies where participants had difficulties in verbalising their experiences (Rosenal, 1995).

When compared to their elicitation by ethnographic interview (Spradley, 1979), written critical incidents tend to be limited by their lack of information depth. Salander (2002) has argued that written critical incidents are invariably too short and may comprise sweeping and generalised evaluations without specifics. By contrast, the ethnographic interview allows the researcher to ask questions of expansion and clarification to obtain additional details about the incident (Fitzgerald, Mullavey-OByrne and Clemson, 1997). As Narayanasamy and Owens (2001) argue, the written generation of critical incidents is best used in conjunction with in-depth interviews, where the issues highlighted in the written narratives benefit from further exploration in the context of an interview. In the context of this PhD study, 'thick description' (Geertz, 1973) was prioritised over any perceived gain in efficiency, and therefore the written narration of incidents was not considered as a primary method for generating incidents.

Another technique for generating critical incidents is by asking participants to draw them. This approach was formulated by the psychologists Cortazzi and Roote (1973; 1975), who outlined the procedure in their text 'Illuminative Incident Analysis'. Although, the drawing of critical incidents has been used as a reflective tool in education, I could find no literature evaluating its use as a data collection method. Thus, this method of generating incidents was not deemed appropriate for this study. A common method used by qualitative researchers (Morgan, 1997; Barbour, 2007; Krueger and Casey, 2009), and one that can also be used in the exploration of critical incidents, is the focus group (Callery and Smith, 1991). However, Farrington (1993) raises the possibility of participants feeling threatened by the process of self-disclosure within a group context. I did not feel that self-disclosure was necessarily an issue for the participants in this PhD study. Indeed, self-reflection in group clinical

supervision sessions is a fundamental aspect of the education of student nurses (Bonham, 2004). Rather, my justification for not using focus groups for the primary method of generating critical incidents is the same reason for not using the written method. That is, the group context does not offer one the prospect of eliciting rich and 'thick' descriptive (Geertz, 1973) critical incidents of student nurses' 'multicultural clinical interactions'.

A further strategy is to use pre-formulated critical incidents (usually elicited in previous interviews) as a stimulus for discussion and the generation of new incidents (Clemson, Fitzgerald and Mullavey-O'Byrne, 1999). In this approach, the participant is asked to reflect on a pre-prepared incident and to discuss what they think is going on in the incident. Usually the same pre-prepared incident is presented to a number of participants and this enables the researcher to engage in comparative analysis across participants and participant groups (Fitzgerald, Mullavey-O'Byrne and Clemson, 2001). For example, the participants may include health professionals, service users and community members, or the groups may represent participants from one or more health professions. This approach was clearly not congruent with the purpose of this PhD research.

There is however, a more useful way of generating critical incidents for the purposes of understanding mental health student nurses' 'multicultural clinical interactions', and this approach was chosen for this study. Based on a similar approach to that used by Fitzgerald and colleagues' (Fitzgerald, et al., 1997a) at the 'Intercultural Interaction Project', ethnographic interviews (Spradley, 1979) were used to generate critical incident data for this research. Fitzgerald (2000) described this approach as the 'critical incident' focused ethnographic interview. According to Spradley (1979, p. 55), an ethnographic interview is "a particular kind of speech event" that is used to generate cultural data.

As I will describe in more depth in a later section of this chapter, critical incidents were elicited from the student nurse participants by asking them to describe a particular situation they had experienced or heard about during clinical placement

where they believed that culture²¹ was important to that situation. I also asked each student nurse participant to describe how that important cultural issue in that particular situation was dealt with. Similarly, I asked each nursing educator participant to talk in depth about a particular situation where culture was an issue for a pre-registered mental health student nurse in clinical placement, and to describe how this cultural issue in that situation was dealt with. In this way, the participant chose the incident or incidents they wanted to relate. Spradley's (1979) typology of ethnographic interview questions was then used to explore the incident and to obtain additional information and the participant's interpretation of the incident. Before I turn to the description of the data collection process, I will first outline the rationale for using the 'critical incident' (Fitzgerald, 2000) focused ethnographic interview (Spradley, 1979) in this study.

The 'Critical Incident' Focused Ethnographic Interview

Asking a person to relate a story (critical incident) from their clinical practice is said to be an effective way to establish trust and rapport with that person (Fitzgerald, 2001). Similarly, Ghaye (2005) describes 'critical incident' storytelling as a relational act, as stories are not only told to others, but there is also reciprocity in the telling of (and response to) the story. Inviting a person to describe a specific event or interaction from their clinical practice tends to be less intimidating and takes away some of the anxieties that the participant may feel if they were asked directly to reflect on their own concepts of professional practice (Brookfield, 1990). According to Brookfield (1987), when more directive questions are put to a person whose ego is invested in being perceived as a competent worker, he or she is hardly likely to admit to experiences that demonstrate their inability "to perform well in a particular situation" (p. 98). 'Critical incident' focused (Fitzgerald, 2000) ethnographic interviews (Spradley, 1979) were especially valuable to exploring the cultural issues in pre-registered mental health student nurses' clinical placements, as these issues were explored "without the obvious social response bias associated with discussing such issues in general terms" (Laws and Fitzgerald, 1997, p. 36). Response bias or translation competence (Spradley, 1979) was reduced by placing the participant in

²¹ The term 'culture' was intentionally left undefined, as it was participants' ascribed meanings about this concept and its perceived influence on student nurses' 'multicultural clinical interactions' that was the study focus.

the role of 'cultural expert'. As Spradley notes, ethnographic interviewing is a means of learning from, rather than studying people.

The 'critical incident' focused ethnographic interview has the potential to access the tacit dimensions and fuzziness (Bruner, 1996) of clinical practice, as during the narration of the incident, the person is talking about themselves without necessarily being consciously aware of this (McAllister, et al., 2006). Critical incidents therefore, provide a means of probing a person's assumptive world. The research literature (Giroux, 2007) indicates that a further strength of this method is the completeness of the generated data. By asking the participant to provide meaningful insights into their own motives and actions, critical incidents can be covered in considerable detail and the researcher can prompt the participant to reveal their feelings about the specific situation (Odawara, 2005). A semi-structured interview may also elicit a fine grained analysis of a person's motives and actions. However, the linkage between contexts, strategies and outcomes (Chell and Pittaway, 1998; Pittaway, 2000; Chell and Allman, 2003) is more readily teased out with an ethnographic interview approach. A 'critical incident' focused ethnographic interview is centred on a specific event that can be explicated in terms of what happened, how it was handled, and what the consequences were. By contrast, a semi-structured interview does not require the participant to focus in such a specific way (Chell, Howarth and Brearley, 1991).

Thus, the 'critical incident' focused ethnographic interview can provide invaluable insights into the psychological and cultural prerogatives that motivated a person's actions (Snell, 1992; Pittaway, 2000), and a running experiential commentary of meaningful events and reactions to those events (Brookfield, 1992; 1993). Importantly, from an anthropological perspective, this approach has the potential to understand complex and meaningful issues in cultural context (Laws and Fitzgerald, 1997). Aside from participant observation, other methods provide little, if any, contextual information; and for socio-cultural anthropologists, context is everything (Fitzgerald, 1997). By contrast, quantitative methods or simple question and answer formats are unable to tease out context and its impact on the situation, and the way that the person interprets it (Laws and Fitzgerald, 1997).

'Critical incident analysis' (CIA) (Cohn, 1989; Parker, Webb and D'Souza, 1994; Ghaye and Lillyman, 1997; 2000; Greenwood, 1998; Ghaye, 2005) has been and is

currently used in the training of student nurses and other health practitioners (Kim, 1991; Arthur, 2004). In particular, it is used to promote clinical reasoning and decision making skills (Cormack, 1996). Indeed, it is generally accepted that reflection on clinical practice is a hallmark of competent professional practice, which allows for the development of new skills, attitudes and knowledge (Schon, 1987; Kemmis, 2004). Critical incident analysis in nursing education involves students in writing about or reflecting on experiences from clinical placement.

Thus, the student nurse participants were already familiar with the concept of actively reflecting on clinical practice and using 'critical incident analysis' to develop learning. This is an additional justification for using the 'critical incident' focused ethnographic interview approach in the research. In a study that evaluated an interdisciplinary health science students fieldwork program in Vietnam (Whiteford and McAllister, 2006; McAllister and Whiteford, 2008), 'critical incident' focused ethnographic interviews provided a structural basis for analysis and meaning ascription that may not have been as well developed through more formal means of data generation. Many of the student nurses in this PhD study reported that reflection on their critical incident stories provoked insights into their own clinical practice. The student nurse participants achieved these insights by drawing on their own accumulated clinical experiences and knowledge. Story telling is a basic form of communication and is consistent with the way that health practitioners interact with colleagues to address issues in clinical practice (Russell, et al., 2002). As this study and previous research has found (Fitzgerald, et al., 1997a; Whiteford and McAllister, 2006; McAllister and Whiteford, 2008), practitioners are comfortable with narrative reasoning and the talk story approach of ethnographic interviewing.

Sampling Process

Selecting the Participants

Prior to the recruitment of participants and the collection of data, institutional review ethical approval was obtained from my host institution and the University nursing school where the research was conducted. As the collection of data took place in four nursing education centres that are attached to a University nursing school, an occupational health assessment and criminal records bureau check was undertaken,

and an NHS research passport was obtained. There were however, administrative problems²² with the new NHS research passport system (introduced in 2009) and frustratingly, the process for acquiring a passport took over a year to be completed.

Pre-registered (years two and three) mental health student nurses were self-selected from four nursing education centres attached to a University nursing school in the north of England. Students from the first year (2010-2011 cohort) of the Diploma/BSc in mental health nursing were not considered for this study, as I felt that they needed time to establish themselves and gain confidence in clinical situations. The nursing educators informed me that during the first year of the Diploma/BSc mental health nursing pathway, many of their students struggled to come to terms with the basic theoretical and applied aspects of nursing. I therefore did not want to further burden these first year students by asking them to participate in the study. Clinical placements during the first year are also less intensive than in years two and three of the undergraduate mental health nursing pathway. In year one, the duration for placements is only eight weeks and involves a placement in a general nursing setting. By contrast, in years two and three of the Diploma/BSc mental health nursing pathway, the clinical practice component is more prominent, as each placement's duration is twelve weeks and takes place in a variety of hospital, forensic and community mental health settings (Bonham, 2004). I felt that it was important that students should have at least one academic year of clinical placement experience behind them; hence my decision to focus the research on years two and three students.

In terms of facilitating access to the University nursing school, a meeting with the professor (who had overall academic responsibility) of the undergraduate mental health nursing pathway was arranged. During this meeting, the theoretical basis, methodology, selection criteria, recruitment strategies, and data collection procedures were discussed. The nature and purpose of the study was then disseminated in the form of an information sheet to the academic coordinators for the years two and three undergraduate mental health nursing pathway. I was then invited by the academic coordinators to give an oral presentation of the research to

²²At one point in the NHS research passport application process, my own personal health information was lost by Human Resources. I only discovered that my health information had gone missing when my GP reported that he had received no contact from Human Resources.

each of the second and third year undergraduate mental health nursing branch cohorts at the four education centres. To ensure a high level of student attendance, the oral presentations were arranged to take place at the beginning or at the end of lecture sessions. Typically, the duration of each presentation was about 15 minutes and an extra 5 minutes was allocated for any student queries. A study information sheet was given to the students at the presentations and sheets were left behind for anyone who was absent at the presentations.

Due to a low student uptake and to achieve 'data saturation' (Lincoln and Guba, 1985), the oral presentations had to be given to all ten student cohorts (2010-2011) across the four nursing education centres. A further study information sheet was then emailed to the students who had indicated their interest in participating in the research. It was likely that the low uptake of students in each cohort to the study was the consequence of the administrative delays in obtaining an NHS research passport. In particular, forward planning of participant recruitment was undermined by this delay, as the passport was not received until half way through the student nurses' academic year (2010-2011). By the time I had arrived on the scene, students were already immersed in completing assignments or engaged in clinical placement.

In addition to the self-selected sample of students, a purposive sample (Patton, 1990) of undergraduate second and third year mental health nursing educators was selected from the academic faculty of this University nursing school. By their depth of experience as clinical educators and as former practitioners (including their own experiences as student nurses), these educators provided important insights about mental health student nurses' 'multicultural clinical interactions' in clinical placements. More specifically, it is in clinical supervision sessions²³ that student nurses share with their peers and educators the kinds of 'critical incident' stories

²³During every twelve week clinical placement, students go back to their nursing education centre for three days of clinical supervision. Clinical supervision sessions typically last between 1 and 1.5 hours, with an additional 30 minutes set aside to talk about any issues deemed inappropriate for group discussion (Ashmore, Carver, Clibbens and Sheldon, 2012). Each session normally has between 10-12 students and one nursing educator. Clinical supervision is defined as "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations" (Department of Health, 1993, p. 15). The purpose of clinical supervision is to encourage students to reflect on their clinical placement experiences, to help identify solutions to problems arising from clinical practice, and increase the understanding of professional issues (Ashmore and Carver, 2000).

discussed in the methodology and findings chapters of this thesis. As a nursing educator explained to me during the course of an interview, "*it is in the clinical supervision sessions when you get to hear their stories and you tend to get interesting stories*". Thus, the nursing educator participants could be described as 'key informants' (Hudelson, 1994), who were considered as "individuals who possess special knowledge, status or communication skills, who are willing to share their knowledge and skills with the researcher, and who have access to perspectives or observations denied the researcher through other means" (Gilchrist and Williams, 1999, p. 74). Key informants are purposefully selected on "theoretical and personal considerations-for the insights and interpretations they bring to the research topic" (Hudelson, 2005, p. 312).

In accordance with the anthropologically informed research design, the aim of the recruitment strategy was to establish the range of cultural phenomena and to select information rich cases that would illuminate the research questions. Including the perspectives of nursing educators and student nurses can be seen as a form of data triangulation (Knafl and Brietmayer, 1989; Flick, 2008b). The triangulation of data sources maximises the range of data, which contributes to a more complete and nuanced understanding of study topics (Krefting, 1991a).

Participants

Thirty six transcripts of interviews with second and third year pre-registered mental health student nurses were analysed. In addition to participating in an interview, a third year student volunteered to write a critical incident narrative. The data set also included seven transcripts of interviews conducted with second and third year undergraduate mental health nursing educators. With the exception of one third year student, background information was clearly recorded for all the student participants. Just over half (n=20) of the student participants were recruited from the second year undergraduate cohort (2010-2011). Most of the participants (n=34) were enrolled on a BSc programme. The other 2 students were studying for undergraduate diplomas. Thirty three of the student nurses identified themselves as from a 'White-British' background, one as 'Black Caribbean', and one each from 'Any Other Ethnic group' and 'Any Other White background'. The majority of the student participants were female, as only six of these participants were male. Just under half of the

participants (n=17) recorded their age as between 18-25, four as aged between 26-30, six as aged between 31-35, three as aged between 36-40, four as aged between 41-45, one as aged between 46-50, and one participant did not record their age band. All of these participants recorded English as their first language; however, five of the participants recorded at least one second language. All of the nursing educators were female and of the lecturer grade. Three of the educators were involved in the teaching and clinical supervision of second year undergraduate mental health student nurses, with the rest of the interviewed educators (n=4) having the same responsibilities for third year cohorts.

The decision to limit the number of student participants to thirty six was based on practical reasons and a feeling that the collected data was sufficient. By the end of the data collection, I had given oral presentations of my research to all the second and third year undergraduate mental health nursing cohorts (2010-2011). Time limitations prevented the additional recruitment of second year students from the following year group (2011-2012). Given the protracted delay with obtaining an NHS research passport and the subsequent problems with recruitment planning and recruiting participants, the ethnographic interviews carried out for this study had generated a sufficient and wide range of 'critical incidents'. I also had the experience which Colaizzi (1978, p. 70) described as "a certain empty but 'distinct' feeling of being satisfied" with the adequacy of the generated data. The length of the critical incidents varied from a few lines to a few pages-and in one case, an entire forty five page interview transcript. These critical incidents provided data about different kinds of placements, from community to hospital and forensic settings.

Data Collection Process

Location and Arrangement of Interviews

It was unlikely that most of the student nurses would of had the time or the opportunity (due to coursework and other responsibilities) to participate in an interview at my host institution; so the participation rate was maximised by conducting interviews at the four nursing education centres which students were attached to. The interviews were normally conducted at lunch time (in between lectures) or after lectures had been completed for a particular day. The students

reported that they found this arrangement convenient, as the interviews fitted in with their tight study schedules and other commitments. On the rare occasions when there were no lectures scheduled, the student was given their travel expenses for attending the interview. A quiet room for the interviews was prearranged with the education centre administrator. Duration of interviews ranged between thirty minutes and two hours. The location of interviews with the nursing educators was predetermined by the educators themselves-generally in the person's office or in a quiet room at the education centre. Duration of these interviews ranged between one hour and two and a half hours.

Ethical Procedures and Recording Interviews

The participant information and informed consent sheet was read out at the beginning of each interview. During this process, participants were reminded of the research purpose, that their participation was voluntary and confidential, and that they were free to withdraw from the interview at any time. In all cases, written consent was obtained. The participant was asked not to use the name of the clinical placement setting or anyone involved in the 'critical incident'. On rare occasions the details of a critical incident was slightly modified to protect the identity of the setting and the people mentioned in the narrative. To help preserve participants' anonymity, student nurse participants are identified only by gender and year of undergraduate study in this thesis.

The recording of the interview was determined by the wishes of the participant; and in all cases, the interviews were audio recorded. Audio-recording of the interviews helped me to listen attentively during the sessions. These audio recordings were kept in a secure and locked place that was only accessible to the researcher. Background information (i.e., contact details, age, gender, ethnicity, and languages spoken) about each participant was collected at the interview's end. The interview notes, audio files, transcriptions, and any other data were destroyed on completion of the study. As a way of showing appreciation and establishing rapport, hospitality in the form of refreshments and snacks was offered to all of the participants. Moustakas (1990) suggests that such measures facilitate a sense of comfort and encourage openness and self-disclosure.

Conducting Interviews

All interviews were based on the ethnographic form or style (Spradley, 1979). The function of the ethnographic interview is to generate cultural data by asking participants 'descriptive', 'structural', and 'contrast' questions. According to Spradley, these question types should complement each other. By using these ethnographic style questions, 'critical incident' (Fitzgerald, 2000) narratives were elicited from the participants. As the incidents emerged through the open-ended process of ethnographic interviewing, their generation was congruent with the cultural constructionist perspective of this study. Each participant chose the incident, or in many cases, the incidents they wanted to relate.

The student nurse participants were asked to describe a particular situation they had experienced or heard about during clinical placement where they believed that culture was important to that situation. I also asked each student nurse participant to describe how that important cultural issue in that particular situation was dealt with. Similarly, I asked each nursing educator participant to talk in depth about a particular situation where culture was an issue for a pre-registered mental health student nurse in clinical placement, and to describe how this cultural issue in that situation was dealt with. These 'descriptive' ethnographic questions elicited utterances in the participant's native language and encouraged the participant to talk about a particular 'cultural scene' (Spradley and McCurdy, 1972) from clinical placement. Spradley (1979) notes that this type of ethnographic question offers the participant a canvas by encouraging them to paint a word picture of their experiences.

Further ethnographic type questions were used to elicit more information (expansion) or for clarification purposes. 'Structural' ethnographic questions allowed me to "discover information about domains, the basic units in an informant's cultural knowledge", and to "find out how informants have organised their knowledge" (Spradley, 1979, p. 60). 'In this particular clinical case, what were all of the reasons that you experienced frustration in your role as a mental health student nurse', was an example of a 'structural' question that I used in the study. Furthermore, 'contrast' ethnographic questions helped me to "discover the dimensions of meaning which informants employ to distinguish the objects and events in their world" (Spradley, 1979, p. 60). 'What were the differences between a case where religion framed a

psychotic illness and a case where religion was not a factor in the framing of psychotic illness', was an example of a 'contrast' question used in the study.

According to May (1991), at the conclusion of an interview, the researcher should ensure that no data are missed (e.g., when 'good byes' are being said). During the closure of interviews (when the audio recorder was switched off) participants frequently mentioned something that was considered relevant to understanding their experiences. On these occasions, I asked participants for their permission to record this information in my field notes. The closure of each interview also involved providing an explanation as to what would happen to the data; assurances regarding the destruction of the audio files following study completion; a brief discussion about the transcription process; asking the participant if they would like to check their transcript through when it was completed; (in the case of student nurses) asking the participant if they would like to take part in a follow up telephone interview to discuss the transcript and any other aspects of the interview session; and asking all of the participants if they would like to participate in a later focus group session (for the purpose of member checking). After every session, field notes describing the context and the process of the interview were recorded.

Transcription and Member Checks

The methodological direction of a study has implications for the form and content of transcripts (Roberts, 2004). This study focused on the thematic content (Lincoln and Guba, 1985; Miles and Huberman, 1994) of 'critical incidents'. As such, the aim of the transcription process was to provide a verbatim and accurate representation of the data content. Once transcribed, a copy of the transcript was sent to the participant for verification and feedback. Participants were asked if they wanted to change or remove anything in the transcript. This strategy reinforces the view that research should be seen as a negotiated process (Doyle, 2007) rather than as something imposed by the researcher. In nearly all cases, changes were minor or additional information was volunteered by the participant. However, in one case, a participant had deleted and edited part of their transcript. The participant stated that the intention of the editing and deletion of material was to protect the identity of her clinical placement and co-workers.

This process constituted the first stage of member checking, albeit at a descriptive level (Seale, 1999). Member checking is basically what the term implies—an opportunity for members (participants) to check (approve) the researcher's interpretation of the data they have provided (Carlson, 2010). This strategy ensured that I had transcribed the interviews accurately and decreased the chances of misrepresentation (Krefting, 1991a). It also presented participants with an opportunity to volunteer any information that was not mentioned during the interviews and to add emphasis to their original accounts (Lincoln and Guba, 1985). The inquiry thus became a more participative and dialogical undertaking (Schwandt, 1996). Many of the participants expressed their appreciation at being given the opportunity to review their account, which provides further evidence of member checking being an ethical act (Cutcliffe and McKenna, 2002).

The transcripts, which were sent to the student nurse participants, also included an attachment where they could write about any critical incidents that they had forgotten to mention at the interview or had occurred since the interview session. Guidance was given for this process. Furthermore, the student nurse participants were given the option of discussing the written 'critical incident', the transcription process and/or what they had discussed during the interview session in a follow up telephone interview. It was recognised that the time for discovery in single face to face interviews was limited (Sobo, 2009) and that leads could be followed up in more detail by conducting telephone interviews.

Repeat interviewing may also prevent some of the problems with social desirability factors and concerns that an interviewee may have in terms of presentation of self (Sobo, 2009). When participants are not available in person (i.e., due to study or clinical placement schedules); telephone interviews are a valuable data collection tool (Sobo, 2003). However, only one written critical incident was elicited and the person in question opted not to participate in the follow up telephone interview. It seemed that a heavy study workload combined with the demands of forty hour week or more placements meant that students simply did not have the time to participate in these activities.

Morse (1998) has argued that the product of qualitative research must be different from the descriptive accounts provided by participants. Therefore, what Lincoln and

Guba (1985) referred to as a 'terminal member check' was conducted at the final stage of analysis. Cutcliffe and McKenna (2002) argue that participants need to recognise something of themselves and their world in the final analysis. Angen (2000) made a similar point by suggesting that the theoretical findings must evoke an immediate feeling of authenticity, a smile of recognition, or an 'ah ha' experience among the participants. This form of member checking, "implies a more cooperative approach between the researcher and the researched" (Angen, 2002, p. 389).

Due to its potential capacity to tap cultural frameworks (Callaghan, 2005) and to "explore any difference in the responses of participants to tentative findings" (Barbour, 2007, p. 90), the focus group method (Stewart and Shamdasani, 1990; Morgan, 1997) was chosen for the final stage member checking. The facilitation of social interaction in a focus group may help "make manifest shared, cultural norms as well as bringing to light important culturally shaped or influenced ways in which people in groups can contest these norms" (Sobo, 2009, p. 179). The potential of member checks to generate further data and understanding is often overlooked in the academic literature. However, Barbour (2007, p. 90) suggests that "presenting preliminary findings can provide an opportunity to involve research participants in working collaboratively to furnish explanations". This is a much more useful approach than viewing such exercises as providing corroboration or validation of one's findings (as is implied in the term 'respondent validation' [Bloor, 1997]) (Sobo, 2009). In the study context, the focus group member checks produced new insights into student nurses' 'multicultural clinical interactions'. For example, 'risk behaviour' was mentioned as a criterion in differentiating mental illness from culturally validated phenomena in the focus groups, but was only briefly and implicitly touched upon in the interview sessions.

Three focus groups were held at nursing education centres closest to the participants and this strategy maximised participation. However, owing to the aforementioned delays with obtaining an NHS research passport, none of the third year cohort of student nurses (2010-2011) was able to attend the group discussions. The third year students had completed their studies by the time of these focus groups, and due to work commitments and other responsibilities were unable to attend these sessions. Furthermore, some of the second year students (2010-2011)

contacted me to indicate that they were unable to attend a focus group discussion due to clinical placement commitments. Three of the nursing educator participants also were absent at the time of the focus group discussions. The students and nursing educators who were able to participate in a focus group discussion were then separated into three different groups (e.g., nursing educator focus group n=4; student nurse focus group 1 n=11; student nurse focus group 2 n=3). There have been strong arguments in the focus group literature (e.g., Morgan and Krueger, 1993; Morgan, 1997) against mixing categories of participants across authority and status lines, because of ethical issues and the probability that the discussion will be uncomfortable at best and conflict-ridden at worst.

Two weeks before each focus group, the participants were provided with a formal invitation letter, a summary of preliminary findings, and a participant information and informed consent sheet. Information and consent sheets were also handed out to the participants at the beginning of the focus group session. In the invitation letter, participants were asked to prepare for the focus group by reading through the summary of findings. As a way of showing gratitude to the participants and to encourage a relaxed atmosphere, refreshments and snacks were provided at the sessions (Krueger and Casey, 2009). At the beginning of each session, the purpose of the focus group was explained, reassurances were given in regard to participants' anonymity, and agreement was secured from group members with respect to participants' confidentiality. In each of the focus groups, the participants were then asked to evaluate whether the themes presented in the summary of findings report reflected their own experiences of pre-registered mental health student nurses' clinical placements. Having secured the agreement of the participants, the focus groups were audio recorded. The duration of the sessions was between one hour forty minutes and two hours thirty minutes. Group members were debriefed at the end of each session and this gave participants the opportunity to raise any issues or concerns. Participants were also asked if they wanted to erase any comments they had made during the discussion. The content of the focus groups was transcribed verbatim.

Data Analysis

Introduction

A thematic analysis based on a constructivist approach (Lincoln and Guba, 1985) was applied to the corpus of data generated from the 'critical incident' focused ethnographic interviews and the three focus groups (member checks). In this analytical process themes and categories are not predetermined, but emerged inductively (Minichiello, Aroni, Timewell and Alexander, 1990; Gibbs, 2007; Saldana, 2009) from multiple reviews of the data (Norton, et al., 1991). This approach to data analysis was compatible with the anthropological orientation of the research design and its emphasis on staying close to the 'emic' accounts of participants. In endeavouring to be more explicit about the processes of constructivist thematic analysis, Lincoln and Guba (1985, p. 344-351) posited some operational refinements. These refinements are concerned with 'unitizing' and 'categorizing' the data. The 'constant comparison' method (Glaser and Strauss, 1967), which was used throughout the analysis process, involves category coding and the simultaneous comparison of 'units of meaning' of all categories, the refinement of categories, and the exploration of relationships and patterns across categories (Maykut and Morehouse, 1994).

I decided not to use computer assisted qualitative data analysis software (CAQDAS), due to a concern that computer analysis packages could alienate one from the data and enforce analysis strategies that conflicted with the methodological orientation of this study. A similar point is made by Seidel and Kelle (1995) in their discussion of qualitative data analysis software programmes. Preliminary analysis occurred in conjunction with the collection of data by writing down recurring ideas, questions and thoughts in a fieldwork journal. Taylor and Bogdan (1998) have described this process as a form of 'discovery', where the goal is to identify an array of potentially important experiences, concepts and themes. More formal and intensive data analysis began when the collection of data was completed and this process is now outlined.

Unitizing the Data

The first step in the analysis process was to identify the chunks of meaning in the data—a process known as 'unitizing' (Lincoln and Guba, 1985), or what Maykut and

Morehouse (1994, p. 128) described as “culling for meaning from the words and actions of the participants in the study”. These ‘units of meaning’ formed the basis of larger categories of meaning (Maykut and Morehouse, 1994). According to Lincoln and Guba (1985), a unit of meaning should have two notable characteristics. Firstly, it should be a heuristic that is aimed at some understanding or some action that the researcher needs to take. Secondly, the unit of meaning must be able to stand by itself-that is, it should be understandable without the need for additional information. The unit of meaning may be a short response, a full paragraph, or something longer (Maykut and Morehouse, 1994). In this PhD study-many of these ‘units’ were much longer than a paragraph, as unitizing short responses and sentences would have overly fractured the data and meant losing the contextual meaning of the critical incidents.

The units of meaning were identified by a careful reading and rereading of transcripts. At this point, the original set of transcripts was set aside and photocopies of the transcripts were used for unitizing and subsequent steps of the analysis. When a unit of meaning was identified, a line was drawn across the page of the photocopied transcript to separate the unit of meaning from the next unit. In the left margin of the page, I then identified the exact location of the unit in the overall corpus of data. For example, the code 5/I/ST/Year 3/P.6, refers to the fifth (5) transcript of an interview (I) with a pre-registered mental health student nurse (ST), a third year student (Year 3) and the sixth page of the transcript (P.6). Similarly, the code 1/I/NE/Year 2/P.3, refers to the first (1) transcript of an interview (I) with a nursing educator (NE), an undergraduate year 2 educator (Year 2) and the third page of the transcript (P.3). In the case of the focus groups, ‘I’ for interview was simply replaced with ‘F’ for focus group. Following Maykut and Morehouse’s (1994) guidelines, the next step was to convey in a word, phrase, or short sentence the essence of the unit’s meaning. This word, phrase, or short sentence was then printed beneath the code for the unit of meaning. When further clarification of meaning and context for a unit was needed, the coding and unitizing of the data made it easy for me to go back to the intact (original) transcript and read the unit of meaning in its fullest context. In accordance with Maykut and Morehouse’s recommendations, the next step involved cutting apart the units of meaning from the photocopied transcripts and taping each unit onto separate 5” x 8” index cards. This

was done in preparation for the ‘categorizing’ (Lincoln and Guba, 1985) of the units of meaning; whereby the units are sorted into provisional categories (Saldana, 2009).

Categorizing

According to Lincoln and Guba (1985, p. 347), the second major step in constructivist thematic analysis is ‘categorizing’; and they provide us with a useful summary of this process:

“The essential tasks of categorizing are to bring together into provisional categories those (units of meaning) cards that apparently relate to the same content; to devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each card that remains to be assigned to the category as well as to provide a basis for later tests of replicability; and to render the category internally consistent”.

The logic underpinning ‘categorizing’ is the method of ‘constant comparison’ (Glaser and Strauss, 1967), which combines inductive category coding and a simultaneous comparison of all the unitizing meaning cards (obtained from the transcripts of data). In this process, each unitizing card is compared to all the other unitizing cards and is then grouped with similar units of meaning to form a provisional category (Maykut and Morehouse, 1994). This ‘look/feel-alike criteria’ was proposed by Lincoln and Guba as a means of describing the emergent processes involved in categorizing units of meaning. Furthermore, when a unitizing card cannot be placed under a tentative category, a new provisional category emerges. During this process, I put aside all the unitizing cards which could not be attached to the provisional categories already formed. Later on in the analysis, I drew upon these unit of meaning cards which I had set aside to form new categories. According to Goertz and LeCompte (1981), there is always a place for further refinement, as provisional categories are changed and merged (or excluded from the analysis) to form new categories. The goal was to develop a set of categories that provided a ‘reasonable’ reconstruction (Lincoln and Guba, 1985) of the data which I had collected.

Following the recommendations of Maykut and Morehouse, a ‘rule of inclusion’ was written-based on the perceived shared meaning of the unitizing cards in a provisional category. This rule was written as a propositional statement, which Maykut and

Morehouse (1994, p.139) defined as “one that conveys the *meaning* that is contained in the data cards gathered together under a category name”. Stated as propositions these rules of inclusion for the identified categories reveal what one is learning about the phenomena under investigation and is a crucial step in arriving at research outcomes (Maykut and Morehouse, 1994). Rules of inclusion for provisional categories then served as the basis for excluding or including subsequent unitizing cards. Data analysis continued until all the unitizing cards had been grouped into substantive categories.

The final step of the analysis was to explore the relationships and patterns across the substantive categories (Lincoln and Guba, 1985). The aim of this process was to examine the propositions that could stand on their own and connect those propositions, which seemed to form interesting patterns and relationships. Maykut and Morehouse refer to the connecting of two or more propositions as ‘outcome propositions’. The final categories and subcategories, which emerged from this study, are discussed in the four findings chapters.

Summary

An anthropologically informed research design (Sobo, 2009) and a qualitative strategy provided the methodological framework for the study. Although the study methodology was not traditionally ethnographic “anthropology’s signature was valid” (Sobo, 2009, p. 76). This anthropological signature was reflected in the data generation, analysis and member checks. Second and third year undergraduate mental health student nurses and their nursing educators were recruited from four education centres that are attached to a University nursing school in the north of England. The ‘critical incident’ (Fitzgerald, 2000) focused ethnographic interviews (Spradley, 1979) helped to explore issues in-depth, in their cultural context, and from participants’ perspectives. These ‘critical incidents’ were based on ‘crises’ (Cortazzi, 2001), ‘social dramas’ (Turner, 1974) and ‘cultural scenes’ (Spradley and McCurdy, 1972), and were therefore, “event-centred” (Yule, 2008, p. 81). Member checking at descriptive and analytical levels was carried out, and these checks allowed for further understanding to take place. The data analysis applied a thematic approach by utilising Lincoln and Guba’s (1985) operational refinements of ‘unitizing’ and

'categorizing' and Glaser and Strauss's (1967) 'constant comparison' method. I now move on to discuss the findings of the study.

Chapter 5

The 'Normative Uncertainty' Evaluation Dilemma: A Key Concern of Clinical Placement

“So in mental health you have this argument about what is normal and what is abnormal, and it can be a minefield sometimes just to get to the core of what is going off”.

(Female 2nd Year Pre-Registered Student Nurse, Interview)

“I don't know why everyone picks religion when they are unwell, it is very strange indeed”.

(Female 3rd Year Pre-Registered Student Nurse, Interview)

Introduction

The thematic analysis (Lincoln and Guba, 1985) revealed that the primary issue to emerge from participants' reports of pre-registered mental health student nurses' clinical placements were the problems presented by the 'normative uncertainty' (Good and Good, 1986) evaluation dilemma. According to Good and Good (1986), this issue is about the challenges that practitioners face when having to determine “whether particular behaviours or forms of experience” are “abnormal and therefore a symptom of illness or simply different but normal within the patient's own cultural context” (p. 11). This concern particularly arose in situations where the student nurse and their colleagues experienced the difficulties of differentiating psychopathology from normal religious beliefs, experiences and behaviours. Assessment serves as the focal point for mental health nursing care, planning and intervention (Ash, 1997; Eeles, 2001; Eeles, Lowe and Wellman, 2003), yet, assessing the significance of religious phenomenology was “fraught with difficulty” (Dein, 2000, p. 173).

The 'normative uncertainty' evaluation dilemma has been the subject of much debate in the related academic fields of cultural psychiatry and psychological anthropology for many decades (Zarrouk, 1975; Prince, 1979; 1992; Rack, 1982; Gaines, 1988; 1995; Dein, 1997; Littlewood and Lipsedge, 1997; Tobert, 2007; 2010). And a central concern of cultural psychiatry has been differential diagnosis and the issue of

religious phenomenology (Lukoff, Lu and Turner, 1995; Jackson and Fulford, 1997; Pierre, 2001; Johnson and Friedman, 2008; Dein, 2012).

To my knowledge, few studies (see, Fitzgerald, et al., 1997a; Sanderson, Vandenberg and Paese, 1999; Eeles, 2001; Kilshaw, Ndegwa and Curran, 2002; Eeles, Lowe and Wellman, 2003) have empirically explored the 'normative uncertainty' evaluation dilemma at the level of practitioners' 'multicultural clinical interactions' (Fitzgerald, 1992). In the profession of occupational therapy, Fitzgerald and colleagues' (1997a) found that 'culture' or 'madness'²⁴ as they termed it, emerged as a primary thematic category in their qualitative study of therapists in Sydney, Australia. In particular, many of the occupational therapist participants reported having assessed beliefs and behaviours that appeared "so alien that they were uncertain whether or not it was a behaviour or belief that should be treated as a mental illness, or if it should be acknowledged as a culturally based artefact" (Fitzgerald, et al., 1997a, p. 65).

Furthermore, Eeles' (Eeles, 2000; Eeles, Lowe and Williams, 2003) qualitative interview study specifically examined what strategies a purposively selected sample of UK registered mental health nurses used to differentiate spiritual experiences from psychopathology. Some of Eeles' research findings are drawn on in subsequent findings chapters, where I discuss how the 'normative uncertainty' evaluation dilemma was dealt with in mental health student nurses' clinical placements. What is new and revelatory about the findings of this PhD study is that the participants were able to identify the 'normative uncertainty' evaluation dilemma as an important issue in placement settings, and could also see its ramifications for clinical practice. These ramifications are a particular focus of the following findings chapter.

The latter sections of this chapter examine what participants saw as the reasons for this clinical dilemma. In particular, there was a perception among some of the student nurse participants that they lacked the culture specific knowledge to make informed judgements about the 'normative uncertainty' evaluation dilemma. In order

²⁴Fitzgerald and colleagues' (1997a) used the term 'madness' for much the same reasons as Estroff (1981) gave for using the word 'crazy' in her ethnography: 'Making it crazy: An ethnography of psychiatric clients in an American community'. They suggest that the term is not used in a diagnostic, sensationalistic, or pejorative way, but rather to reflect the everyday discourse of mental health professionals, service users, and the general public.

to overcome these perceived knowledge deficits, a few of the participants suggested that informational resources with culture specific content should be made readily available in placement settings. Furthermore, formal education about the 'specific' beliefs and practices of religious groups was recommended. Finally, I identify the pitfalls of applying culture specific knowledge to clinical issues, by drawing on the relevant academic literature.

Delusions or Religious Beliefs

Drawing on the work of Goodwin and Jamison (1990) and Podvoll (1987), Simon Dein (2004) has suggested that there is frequently an overlap between mental disorders and religious problems (especially in manic episodes, which may have mystical aspects), which makes it difficult to differentiate religious beliefs from frank delusions. Indeed, many of the mental health student nurse participants expressed uncertainty about when a service user's religious beliefs had become pathological. Were the service users' expression of beliefs delusional and therefore connected with their diagnosis of psychosis, or were they associated with normal religious thinking?

"We had in a guy on placement who was a Jehovah's Witness, and he was really involved in his church. It was hard, because as he was becoming more ill, it was hard to distinguish between what was part of his religion and his bipolar. I mean, this person had been diagnosed with bipolar. It was hard to distinguish between what was part of his mania, what he had sort of created for himself, and what his religious beliefs were before the mania. It was difficult to distinguish between those factors. I did not know him before his illness, but he was quite ill when I came across him on that placement. He was sort of incorporating....But I do not have a lot of knowledge either about what Jehovah Witnesses believe. But he sort of incorporated it, and in the end he thought he was going to be the leader of a new sort of.....There was going to be an end of the world, an 'Armageddon'. And he believed he was going to lead everybody to a sort of new land, because he had been getting messages through from the newspapers that this was going to happen. He would also quote things from the Bible about what was going to happen and how he was going to be really involved in this new beginning.

It was hard to know in this case, as he was very religious anyway, especially in the way he would talk and quote things from the Bible. He also had really high morals. But he would also quote things from the Bible when he was talking about this new world as well. So it was difficult to make that distinction. It was difficult to be able to communicate and know what he was talking about if that makes sense? All I can say is that it was very difficult to make that distinction between this person's religious beliefs and what they were experiencing as part of a manic episode".

(Female 2nd Year Student, Interview)

“Religion as an issue does pop up a lot for me when I am out there working in clinical practice. When someone with psychosis is on about hearing God, but they are also Christian, it is difficult to know when it is a genuine religious experience, or whether it is the result of chemical imbalance, or they have been smoking too much weed. So it is particularly difficult when that person is already religious to ascertain wherever that belief is part of delusional thinking or part of a genuine religious belief. There was actually someone on an acute ward that I worked on who believed he had been sent to the ward by God. It was his mission, and he was using a lot of the lingo that you hear at churches, especially in the evangelical churches. And he was utterly convincing to the point where I am still in doubt whether he was ill or not”.

(Male 2nd Year Student, Interview)

The nursing educator participants reported that these concerns were often brought up by their students in clinical supervision sessions and lectures.

“Yeah, the issue of communication does come up in the sessions with the students, and especially when the students have to respond to people who have quite bizarre speech and unusual ideas. And often they don’t know what to say to the client, how to respond, and what to believe. And it kind of fits in with what I was saying earlier about the problems the students have in making that determination of psychosis when religious beliefs are present”.

(Nursing Educator, Interview)

“And I think that certainly in clinical supervision when the students bring up issues that occurred to them while they were out there on placement. You know? They will say something like; ‘I’ve got this patient and I don’t know what’s going on with them. They keep saying this, but then they had relatives come in on to the ward and the relatives seem to share all these beliefs and so they can’t all be unwell’. And that tends to come up quite a lot in my clinical supervision sessions with the students. What they want is a definitive, ‘is this religion or is it part of that person’s disorder’? And sometimes they struggle with that grey area in between-where we don’t know. Maybe, it’s important as instructors, to try lots of different routes to address it”.

(Nursing Educator, Staff Focus Group)

These narratives brought to mind Cutcliffe and McKenna’s (2000) assertion that one of the fundamental skills in being a mental health nurse is to cope with constant ambiguity and exceptions to previous and established ways of thinking.

A small number of the participants mentioned that it often was easier for the student nurse to establish psychopathology when the content of a service user’s beliefs was about something other than religion.

“The focus of last week’s lecture session was working with someone who was suffering from psychosis and who was perhaps experiencing unusual beliefs and delusions. There was a consensus in the group that it was more difficult to work with people who have some kind of religious belief. We were looking at a DVD-where someone in the programme was talking about the religious visions that they saw. They thought that the mother of God appeared in one of their delusions and we talked about that afterwards. Most of the people in the group felt that they were less likely to challenge those kinds of delusions with a religious content. However, I don’t like to use the word ‘challenge’, as it should not be about challenging beliefs, but about getting people to think about alternative ways of thinking about those beliefs. I think that students feel uncertain when working with people who have religious beliefs and where the content of their delusions may be based on a religious theme. They feel less certain in dealing with those beliefs when compared to working with someone who believes that they have got a computer chip in their brain, or there is a conspiracy to harm them. It can be difficult for students to differentiate genuine religious belief from a delusion”.

(Nursing Educator, Interview)

Trying to ascertain the ‘falsity’ of the service user’s beliefs may not get the student nurse very far. As Pierre (2001), and more recently Simon Dein (2012) explained, one cannot apply the criterion of ‘falsifiability’ to beliefs which are non-empirical and non-falsifiable. Dinesh Bhugra (1996) writes that the findings of anthropology is full of instances where similar mental/behavioural states were defined as psychopathological phenomena in some cultural contexts and religious experiences in others. A typical example is ‘glossolalia’ or ‘speaking in tongues’, which is a common phenomenon in Pentecostal (‘Charismatic’) types of Christianity (Grady and Loewenthal, 1997; Littlewood and Lipsedge, 1997). As various academics (Young, 1967; 1976; Landy, 1983; Eisenbruch, 1990; Dein, 1997; Helman, 2000; 2007; Tobert, 2007; 2010) have acknowledged, many people from culturally diverse backgrounds will hold multiple explanatory models (Kleinman, Eisenberg and Good, 1978) for distress and ill health. Moreover, these models include physical and non-physical (i.e., supernatural) causes of illness. In many cases, these explanatory models are fundamentally different to ‘absolutist’/‘universal’ biomedical models (Offer and Sabshin, 1966), which assume that illness is the manifestation of organic disorder located within the person’s body (brain) (White and Marsella, 1982; Littlewood, 1990; Seeley, 2006; Marsella and Yamada, 2007). Tobert (2007, p. 5) observes, that the “non-physical aspects of reality are important for our re-evaluation of certain religious experiences, in particular those where the person experiencing or those near to them have either questioned the validity of the experience, or

considered it a symptom of a psychiatric condition". This anthropological evidence calls into question existing assessment criteria for delusions, which have emphasised their content, 'bizarreness', or 'falsity' in order to classify them as pathological (Peters, 2010).

There also is a growing recognition that delusions are not categorical phenomena, but instead, exist on a continuum with 'normal' beliefs (Peters, Joseph and Garety, 1999; Peters, Day, McKenna and Orbach, 1999; Peters, 2010). Moreover, the discontinuity model for delusions has been questioned by epidemiological research using standardised diagnostic instruments. These epidemiological studies found that 10 to 28 per cent of the general non-psychiatric population experienced delusions, whereas the prevalence of psychoses is estimated at around 1 per cent (Eaton, Romanoski, Anthony and Nestadt, 1991; Kendler, Gallagher, Abelson and Kessler, 1996; Van Os, Hansen, Bijl and Ravelli, 2001). In accordance with the continuum model for delusions, assessing the presence or absence of a delusion is informed by the careful consideration of their dimensions (Pierre, 2001; Peters, 2010). According to Mohr and Pfeifer (2009, p.86), none of these dimensions "is necessary or sufficient, but adding one to the other, result in greater likelihood of a delusion". Thus, it is the degree of acceptance by the person's religious community (which replaces the criterion of 'falsifiability') and its dimensional characteristics (conviction, preoccupation, negative affect [emotional distress], and extension [the impact of the delusion on a person's life]), which are important considerations in assessing the clinical significance of religious beliefs (Pierre, 2001; Dein, 2012).

Normative Uncertainty and the Clinical Concept of 'Insight'

While the clinical concept of 'insight' is typically used as a diagnostic criterion of schizophrenia (Endicott, et al., 1982) and in mental health nursing, as a key indicator of treatment compliance (Pinkihana, Happell, Taylor and Keks, 2002; Coombs, Deane, Lambert and Griffiths, 2003; Hamilton and Roper, 2006), for several of the student nurse participants, it seemed more to raise the 'normative uncertainty' evaluation dilemma.

"I remember that when I was working out on community placement there was this African lady patient who believed that the voices she was hearing was connected to her religious beliefs. She thought that was perfectly acceptable for her to believe, but in this culture, it is not acceptable to believe that. Rather, these voices and beliefs are

connected to an illness such as psychosis. And she had to have depo injections for what was diagnosed as schizophrenia. She did not want to have those injections, as I think that from her perspective-psychiatric medicine was unacceptable. Rather, she believed that what she was experiencing had a spiritual basis. That seemed to be her cultural worldview if you like.

From my perspective, I felt very torn about that and I felt very uncomfortable about getting involved with that. She was eventually taken back into hospital, and it was very upsetting to hear that. She talked to herself a lot and she would come in to have the depo injection, but she thought she was losing her soul when she was having the injection. She thought that what she was experiencing in terms of her distress was connected to this soul loss. She felt the mental health team were not listening to her about her concerns, and were taking her spiritual beliefs away from her. They were denying the reality of her spiritual beliefs and putting it down to a lack of insight. I don't think it was in her belief system to have Westernised medicine, and I felt that was enforced on her whether she liked it or not. I did not feel there was any attempt to understand this lady's cultural beliefs. I am not saying that she was not ill, as obviously, when you look at it from the vantage point of this society and psychiatry, those beliefs and the symptoms of speaking to yourself and hearing voices are indicative of a psychosis. So in that situation, I think it is very difficult to interpret whether it is down to cultural beliefs or a psychosis. And in the culture of mental health services, the fact that she believed she was suffering from 'soul loss', means that this lady does not have insight into her illness. But I think everything was just passed on as part of her illness".

(Male 2nd Year Student, Interview)

"I am actually working with a lady client of Lebanese origin on an older adult assessment ward. She has had acute psychosis, delusions, and she is still responding to auditory and visual hallucinations. She does not believe she is poorly. Rather, she thinks about her condition in a godly sense. And what she has told me and from some of the evidence I have read, that it is acceptable within her culture to hear voices and experiences and these types of hallucinations. It is seen as a gift that is given to them. It is currently a struggle, as she is on a Section 3. She is very upset, as she does not want to be having these depo injections anymore. It is difficult, as she has been assessed that she has no insight into her illness. It seems like the sensible thing to do is to treat her, because we have got a lady who from previous history is known that if she does come off these injections, she is going to be acutely psychotic. The doctor is saying that she has got no insight, but she does, because it is her beliefs. There are patients out there who of course do not have insight, and once they are well, they will look back and think I was really poorly. There are some patients who will never accept they are ill, because that is not their background and that is not their beliefs. So it is our beliefs and our judgements that we do put upon some of our patients.

This lady does talk to me about where she is from and her community, and she was telling me about a relative of hers. I believe it was her nephew and he had visual and auditory hallucinations. And in her community in Lebanon, it was seen like a gift from the spirit world. It was given to them by the spirit world to approach other people and to talk about things they would not normally be able to talk about. They were like messages to other people in the community. It is a hard one, as it is about our beliefs

and what we feel is right for the individual, which depending on their history and background, may not be the right thing to do. I think that it is a futile attempt really to get her to agree with it. It is something that she believes in so strongly”.

(Female 3rd Year Student, Interview)

These narratives bring to mind cultural critiques of the clinical concept of ‘insight’ (Lazare, 1989; Littlewood, 1990; Perkins and Moodley, 1993; Johnson and Orrell, 1995; 1996; Beck-Sander, 1998; David, 1998; McGorry and McConville, 1999; Saravanan, et al., 2004; 2005; 2007a; Hamilton and Roper, 2006; Lipsedge, 2007; Fernando, 2010; Jacob, 2010). In particular, how its assessment can alternatively be viewed as a judgement about the discrepancy of the service user’s explanatory models (Kleinman, Eisenberg and Good, 1978) with that of the biomedical model. Thus, the assessment of insight can be a form of control and a way of dismissing the (‘emic’) perspective of the service user who resists the biomedical interpretation of their illness and help-seeking strategies (Kilshaw, Ndegwa and Curran, 2002).

Research evidence also suggests that in some cases, service users will try to protect themselves from the stigma of mental illness by denying its existence (Kennard, 1979; Lally, 1989; McGorry, 1992; Johnson and Orrell, 1995; Hsu, 1999; Hudelson, 2005; 2006; Perron and Hudelson, 2006). As Kilshaw, Ndegwa and Curran (2002) argue, a person may deny that they are ill not as a consequence of the illness, but as a conscious effort at self-protection. Similarly, Johnson and Orrell (1996, p. 1084) note that a lack of insight could be “a way of coping where the patient finds the implications of a diagnosis of mental illness or the prospect of treatment very unacceptable”. These issues particularly are salient for marginalised cultural groups who have justified concerns about psychiatric medicine and the sorts of interventions it offers (Fernando, 1988; 1998; 2002; 2009; 2010; Bhugra and Bahl, 1999; Bhui, 2002; Ndegwa and Olajide, 2003; Sewell, 2009). Resisting interpretations and diagnostic labels may even be seen as important statements (Kilshaw, Ndegwa and Curran, 2002). Saravanan et al. (2004; 2005) have responded to such criticisms of the clinical concept of insight, by recommending that cultural perspectives be taken into account in assessment. In particular, they encourage practitioners to bring the evaluation of insight in line with the DSM-IV’s (American Psychiatric Association, 1994) guidelines on the cultural assessment of delusions.

Religious Experience or Psychotic Hallucination

The participants also described the problems with differentiating psychotic induced hallucinations from religious experiences, although this issue was mentioned a lot less than the reported difficulties with assessing the clinical significance of religious beliefs. For the participants who mentioned this issue, the question posed was about whether the auditory, tactile, or visual phenomena experienced by the service user was an indication of a genuine experience that was congruent with the person's religious background, or was it suggestive of psychotic induced hallucinations?

Hearing voices has been classified in psychiatric nosological criteria (American Psychiatric Association, 1994) as a classical feature of schizophrenia. However, in the next 'critical incident' (Fitzgerald, 2000) story, the student nurse participant recalled the dilemmas she had encountered when determining the clinical significance of such phenomenology.

"I guess she must have been admitted somewhere else, and they then sent her to our ward. In her notes, it said that she saw this figure that she had a name for. She described the figure as a black man and she had a name for it, but it did not seem to be someone whom she knew. Sometimes, it was a negative experience and then at other times, it was a positive experience. When it was a positive experience, the figure was guiding and helping her. But sometimes, it seemed to be more frightening for her. It was mentioned by some of the staff on the ward that her description of the figure seemed to fit a support worker who was a tall black guy. And there seemed to be some people who were making a link between this support worker and the figure that she was seeing. But I was not personally convinced by that explanation. Anyway, she described seeing a figure and hearing his voice. She was also experiencing other voices too. When we asked her what the voices were like and what they were telling her, it did seem to fit with a religious experience. This seemed to be the case, as the voices were telling her about what she should be doing, how she should live her life, and what sort of person she should be. But then I guess you could get the same kind of answer from someone who is experiencing psychosis. So I do not know what to think in that case".

(Female 3rd Year Student, Interview)

The accurate assessment of hallucinatory phenomena is said to be pivotal for culturally diverse service users, as in certain cultural contexts, hearing voices when no one is there and seeing images of dead relatives can be related to cultural expectations and religious beliefs (Guarnaccia, et al., 1992; Guarnaccia and Rodriguez, 1996; Loewenthal, 2007). Zandi (2013) draws on the research findings of Al-Issa (2000) and Alsughayir (1996) to explain that hearing voices is "a key presenting symptom of emotional problems, which sometimes is perceived to be related to supernatural events" (p. 220).

It has been proposed that perceptual experience lies on a continuum (Wiebe, 2004) and 'hallucinatoriness' occurs in degrees (Dein, 2012). Van Gemert (1998) has suggested that when experienced as occurring from inside the head, the hearing of voices can be a normal experience of thought, and this suggestion is backed up by a growing evidence base, which shows that hearing voices occurs among the general non-psychiatric population (Romme and Escher, 1989; Tien, 1991; Poulton, et al., 2000; Van Os, Hansen, Bijl and Ravelli, 2000; Johns, Nazroo, Bebbington and Kuipers, 2002). Another epidemiological study (Bell, Halligan and Ellis, 2006) found that when considering hallucinations in the domains of taste, sound, sight, touch, and smell, an estimated 11 per cent of the general population scored above that reported with psychotic inpatients.

Thus, the differentiation of religious phenomenology from the positive symptoms of psychotic illness is important to the assessment process (Zarrouk, 1975; Al-Issa, 1977; Rack, 1982). Hallucinations with religious themes are not amenable to empirical corroboration; therefore, Dein (2012) recommends that their clinical relevance should be assessed by using similar multidimensional criteria to delusions with religious content. That is, they should be assessed for their impacts on functioning, the distress associated with them, and whether they are validated by members from the service user's local context and community.

A Three Way Dilemma

A few of the critical incidents raised by the student nurse participants posed a slightly different question in regard to the 'normative uncertainty' evaluation dilemma (Good and Good, 1986). In fact, these participants mentioned a three way dilemma that they had encountered in clinical placement. The question that was raised here was not just about whether the service user's behaviour was religiously motivated or was a product of psychopathology, but whether the service user was being a 'difficult patient' (Lau, 1988; Miller, 1990; Stein, 1990; Lupton, 1994; Duxbury, 2000).

In the next narrative, the student nurse participant talked about the difficulties she had with making an informed interpretation of what seemed to be non-compliant behaviour. The question posed by this student nurse was not just about whether the non-compliance could be explained by psychopathological factors or the service user's religious background, but whether it was actually a conscious 'act of

withdrawal' (Duxbury, 2000). According to Miller (1990), an 'act of withdrawal' is the refusal to interact or to cooperate due to disinterest, denial, fear, protest, or for some other reason.

"So it came around to doing these physical observations with this Muslim gentleman. He told me that he could not do it on religious grounds, as it was against his religion for a woman to touch him. I said to him that 'it would really help if we weighed you', but he did not want to have anything to do with it. I said to him; 'would it help if I could get a gentleman to do the readings with you? I can arrange that for you if you wanted me to'? So I said to him; 'I would like you to please get on the scales and I will not make any contact at all, and you can take the measurements for me'. He did not want this bloke (nurse) to do it either. He did not want me or any other female to do it, but he did not want this bloke to do it either. In fact, he did not want anyone to go near him.

The thing is, in the past he had sort of agreed. In a way, the staff thought he was being a bit.....I don't know? I wonder whether in that case it was to do with culture, as he was saying it was against his religion and culture to allow anyone to touch him or be near him, or if he was just being difficult. I feel difficult saying that, as he had these physical observations in the past, but he was also renowned for being difficult. I was there for three months and not once did he have the readings taken. But it leaves you in a situation where you think, well how many times do I ask and should I be really asking? He said it was against his religion and I tried to accommodate it; either for him to do it, or for this guy to do it. But he still did not want to be part of it. So in the end the physical observations got left.

I think he had the physical observations done about six months ago or something. And this is why I did not know if he was being difficult, or if it was for a genuine reason. Every time I turned over the page, I could see a couple of more instances, but on this occasion I had to put down 'refused'. To be honest, in that case I did not know which it was. I mean, he could have been just difficult, and on the few occasions when he had done it in previous months, he might have just done it off the cuff and not thought about his religion. But certainly, it provoked a question in my mind, about which was that?

And the second thing was in relation to interrupting him when he was listening to his music, which was part of his religion and also was used to block out the voices he was hearing in his head. However, at some point you do need to talk to people. I don't want to sound bad, but it seemed as if he was using that as a reason for everything. And I am sure that there was a genuine reason behind some things, but we had quite a lot of people on there that had quite severe mental illnesses and he was quite paranoid as well. But it felt to me that he used it as a reason; like off the cuff, he would say 'leave me alone', and 'I do not want to talk about it anymore'. I think it was difficult in that situation, as there was a problem in determining whether this behaviour was part of his illness or part of his religion. Or was he just being difficult? But because you very much want to accommodate all cultural preferences and consider equal opportunities, you do not want to judge that either way".

(Female 3rd Year Student, Interview)

According to Duxbury (2000), the concept of 'difficult patient' means different things to different people, and nurses may not always identify the same difficult patient on their wards, units, or caseloads. Nurses can have models of 'difficult' patients (Lupton, 1993), or an "unofficial, moralistic taxonomy of types of patients" (Stein, 1990, p. 98), which exerts an influence on the way that service users are treated in care settings. 'Difficult patients' often have been identified as persons presenting behaviours which create barriers to effective nursing care (Duxbury, 2000), and who make nurses feel frustrated, uncomfortable, or ineffective (Miller, 1990).

'Normative Uncertainty' and Culture Specific Knowledge

There was a perception among some of the student nurse participants that they lacked the culture specific knowledge²⁵ to respond effectively to the 'normative uncertainty' (Good and Good, 1986) evaluation dilemma. These participants mentioned that it was often difficult to assess the clinical significance of religious phenomenology when one was unfamiliar with the normal range of religious beliefs and practices that existed in a service user's culture. This concern was brought up by participants in both the 'critical incident' (Fitzgerald, 2000) focused ethnographic interviews (Spradley, 1979) and the focus group sessions.

"As I said before, it was hard to tell if they were actually religious references. Maybe, if I had more knowledge about the Koran I may have recognised some of those religious references. It was difficult in that case without some kind of knowledge to determine whether that was something related to what was said in the Koran, or was it just an expression of her psychosis, or was it even a bit of both? Were we just dismissing her concerns, assuming things were due to her psychosis, and ignoring a genuine religious need? And in her mind, she might have thought that I am trying to tell you about something really important and you think I am talking about fairies. And in that case you just did not know and you could not really have known. Maybe, if I had read the Koran right through, I might have done. I remember one of my lecturers saying to the class that 'if you ever want to deal with mental health, you need to read the Bible'".

(Male 2nd Year Student, Interview)

²⁵In the context of the health and nursing sciences, 'cultural knowledge' involves obtaining information about the worldviews of different cultures (Campinha-Bacote, 1999). According to McPhatter and Ganaway (2003), cultural knowledge may allow the practitioner "to enter the world of culturally different clients in a manner that understands and preserves the legitimacy of the culture and effectively meets their needs" (p. 107). 'Culture specific knowledge' in particular, is associated with the ability to act competently within the context of a cultural group (Fitzgerald, 2000). Practitioners require a detailed knowledge of the specific cultural backgrounds of their service users in order to achieve this level of cultural competency (Harris, 2004; Suh, 2004).

“I found it really difficult to assess when the patient’s culture was alien to me. I didn’t really know anything about Sikhism, even though I do know a little bit more about Sikhism now. But it is something that I do not really know much about. So in those types of situations, I couldn’t really differentiate between what are normal beliefs of the religion and what are delusional beliefs that are part of an illness”.

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

According to another student nurse, the ‘normative uncertainty’ evaluation dilemma occurred with service users who held very different religious worldviews to their own.

“I find it more difficult to differentiate a genuine religious belief from a delusional belief when it involves somebody who holds different religious beliefs to my own. This is because I am not fully aware of what their God says or what their teachings are. So it is harder to differentiate between a psychosis and a genuine religious belief when it is to do with another religion. It is not so hard to do with Islam, as that belief system is very similar to the Judeo and Christian kinds of traditions. But when it is to do with other faiths, such as Hinduism and Buddhism, you are dealing with that existential oneness which I am becoming more aware of through the experience of working with patients with those sorts of beliefs. But for me it is still harder to relate to. I would not be able to say with confidence that is an illness or that is an expression of a religious belief”.

(Male 2nd Year Student, Interview)

Academics in the related fields of cultural psychiatry and clinical anthropology also have noted the difficulties with making a differential diagnosis where the practitioner is unaware of the range of normal beliefs, experiences and practices in the service user’s culture (Westermeyer, 1987; 1993; Levy, 1996; Dein, 2000; Paniagua, 2001; 2005). For example, Paniagua (2005) suggests that practitioners unfamiliar with the Hispanic cultural belief system of ‘spiritual faculties’ (which from the perspective of believers enables one to communicate with entities that live in an invisible world) are more likely to interpret such reports as signs of severe psychopathology. As Guarnaccia and colleagues’ (1992) explain, specific symptoms may have particular cultural meanings which can present challenges to the assessment process; and without some cultural knowledge of the service user’s experiences, and questions that tap these dimensions, accurate assessment using standard psychiatric nosology is difficult to make. Practitioners need to be at least aware of the religious issues that they are likely to encounter in clinical practice and assessment, and may require additional education about the major teachings of religious groups (Dein, 2000).

In some cases, the student nurse participant mentioned that they had made a determined effort to research the religious backgrounds of their service users. These attempts at self-education however, were not always successful.

“I was looking for information on the internet with the other nurses to inform our judgement about whether that patient’s beliefs were a product of a psychosis or a product of his culture. However, it is difficult to know what is useful on the internet. You do not know what is appropriate or what to look at on the internet”.

(Female 3rd Year Student, Interview)

“In the case of the woman patient with the new age beliefs, who am I to say that her practices do not exist and don’t actually have any bearing on what is happening. I guess there is also something about an Englishman that he retreats from something he does not know about. I am guilty of that as anyone else I guess. I mean, I did not understand this lady’s beliefs, so I did some self research in an effort to understand them. But even after I researched the topic, it still perplexed me somewhat. I still had no idea what this lady’s new age beliefs were about”.

(Male 2nd Year Student, Interview)

Considering these problems with locating relevant culture specific information, a few of the student nurse participants suggested that informational resources with such content should be made readily available for students to use in clinical placement. It was felt that these informational sources would enable student nurses to make more informed judgements in regard to the ‘normative uncertainty’ evaluation dilemma.

“It would have been easier to establish trust with this patient if we had some kind of resource. It would have been better if we had more information about him as an individual as well. It took a while to get access to his older notes. So at first we were going in pretty blind really. We eventually found more about his previous beliefs and his mother’s beliefs from his notes. When we spoke to him, he did not offer any information about these beliefs. However, it was obvious that they had a massive impact on his life. So a resource would have been helpful. We had some basic training on the nursing course. We were recommended a book which contained information about different cultures. However, I have not seen such books during clinical placement. I think it is important to have those kinds of books made accessible on the ward, as there is a very fine line between being very religious and being mentally ill”.

(Female 3rd Year Student, Interview)

Male Student 1: *“I think it would be good to have some actual resources on the wards that you could refer to. That is really important when those assessment issues we talked about emerge”.*

Male Student 2: *“Like a handbook or just a basic outline”.*

Male Student 1: *“You don’t even need to go into too much detail. Just like this is a Jehovah’s Witness and this is the key tenets of their beliefs. And then if they are saying something different to that you may think, well that is maybe more on the delusional side. You know? It does not appear to be conforming to the typical Jehovah’s Witness belief system”.*

Male Student 2: *“Yes, yes, exactly”.*

Male Student 1: *“And so a reference system on the wards might help with that”.*

(Pre-Registered Mental Health Student Focus Group N 1)

Formal education about the beliefs and practices of religious groups was also recommended by a few of the participants.

“We had some sessions at University about spirituality and cultural diversity. In those sessions, we have talked about the fact that spirituality is a big part of a person’s wellbeing in general. So we need to take that into account when thinking about a person’s care. But I would not say we have received any specific practical skills for dealing with people from different religious backgrounds. Like for example, what would you do if somebody was talking about an experience they had and how would you assess that? We have just been given starting points for thinking about that sort of stuff. So yeah, they were interesting sessions, but I do not think it necessarily prepared you for demanding situations such as assessments”.

(Female 3rd Year Student, Interview)

“I think we should have some more lessons on religion, as it has been a topic that has been a bit neglected in our studies. I think I would like to know something about every major religion, as you can then talk about it with someone and learn from their experience. I mean you do not know the Bible or the Koran back to back, but you are able to start a conversation about it, so you can discuss it with them. That is comforting for someone who is religious, as it is such a big part of their lives. It is also important when it comes to our assessments. Because sometimes, I would like to back up what they have said about their beliefs or maybe challenge it”.

(Female 2nd Year Student, Interview)

These requests for more culture specific knowledge brought to mind the ‘fact file’ or ‘cookbook’ approach to cultural competence (Culley, 1996; 2000; 2001; 2006; Gunaratnam, 1997; 2001; 2004; 2007; Fitzgerald, 2000; Galanti, 2001; 2005; 2006; 2008; Taylor, 2003a; b; 2010; Dein, 2006a; Lee and Farrell, 2006; Galanti and Sheikh, 2009; Joralemon, 2009; Carpenter-Song, 2011). In this approach, a description is given of the supposed core beliefs, customs, and practices of a cultural group. A textbook by Purnell and Paulanka (1998) for example, offered structured overviews of 16 ethnic groups, with sections on specified domains of culture.

It may be the case that culture specific information and education will help student nurses to respond effectively to the challenges of the 'normative uncertainty' evaluation dilemma. Such knowledge may provide the student nurse with a useful 'starting point' (Bonder, Martin and Miracle, 2002) and thus, to anticipate potentially relevant issues. Writing in a similar vein, the nursing anthropologist Galanti (2008) suggests that if culture specific knowledge is used as a 'guide post' rather than as a precise 'blueprint', it ideally will assist the practitioner to anticipate possibilities that should be considered, and make sense of phenomena that have already occurred. However, as a starting point, further information is needed to "ascertain whether the statement is appropriate to a particular individual" (Galanti, 2008, p. 7).

Significant problems can emerge where no effort is made to learn "whether the individual in question fits the statement" (Galanti, 2008, p. 7). One result is that one size fits all mobilisations of culture lack relevance for service users as well as practitioners (Shaw, 2005). As Fitzgerald and colleagues' (1997a, p. 94) explain, if the practitioner assumes:

"That because this person is from a particular culture and their speech contains reference to something considered symbolic in that language and then assumes the person is speaking symbolically, but they are having hallucinations, the end result can be just as serious as if the story went the other way around".

The vital point to consider when applying culture specific information to the 'normative uncertainty' evaluation dilemma is that one cannot just assume a service user is drawing upon symbolic language and/or behaviour (Fitzgerald, et al., 1997a).

Indeed, it is important for student nurses to recognise that all phenomena and interpretations of phenomena are culturally constituted, and this is no less the case for illness experiences (Fitzgerald, et al., 1997a). Clinical anthropologists for a long time now have argued that the manifestation of psychopathology cannot be separated from cultural theories about illness and premises about social behaviour more generally (White and Marsella, 1982; Dein, 1997; Jenkins and Barrett, 2003; Helman, 2007; Watters, 2011). As Fitzgerald and colleagues' (1997a, p. 95) note, the "way we think about such illnesses, communicate about them, behave in conjunction with them, and interpret such thoughts and behaviours are all mediated by symbolic forms of, and from, language and culture".

According to Weinstein (1962), a person suffering from mental illness will often employ the dominant symbolic system for their cultural group. However, they are likely to do so in a manner that seems inconvenient and clumsy to others. In the case of schizophrenia, Jenkins and Barrett (2003, p. 6-7) have described the general state of affairs as thus:

“In sum, what we know about culture and schizophrenia is... (that) culture is critical in nearly every aspect of schizophrenic illness experience: the identification, definition and meaning of the illness during the primordial, acute, and residual phases; the timing and type of onset; symptom formation in terms of content, form and constellation; clinical diagnosis; gender and ethnic differences; the personal experience of schizophrenic illness; social response, support, and stigma; and perhaps most important, the course and outcome with respect to symptomatology, work, and social functioning”.

This reinforces the important point made earlier, that the student nurse, must not just assume (based on culture specific information alone) that the service user is using symbolic language or behaviour (Fitzgerald, et al., 1997a). The student nurse needs to be aware that culture influences the use of language and symbolism and it influences how symptoms are manifested and expressed (Nichter, 1981). To use Fitzgerald and colleagues’ (1997a) insightful reference to Bock’s (1980, p. 38) interpretation of a statement made by Sigmund Freud; “things are seldom what they seem to be”.

When expectations are disconfirmed (Brislin, Cushner, Cherrie and Yong, 1986; Mullavey-O’Byrne, 1994a; b; Mullavey-O’Byrne and Fitzgerald, 1995), it “can lead to a sense of cultural dissonance and dissatisfaction and a lack of ability to deconstruct or interpret the situation in a way that leads to satisfying solutions and strategies for care” (Fitzgerald, 2000, p. 186). I have discussed in the literature review, how ‘disconfirmed expectancies’ are often the basis for the kinds of ‘critical incidents’ that arise for practitioners in ‘multicultural clinical interactions’ (Fitzgerald, 1992). These issues are more likely to occur, where student nurses have to juggle the competing demands of managerialism, time constraints, and person-centred care (Fortune, 2002; Fortune and Fitzgerald, 2009). As one nursing educator succinctly described it:

“They (mental health student nurses) were only on the placement for a limited amount of time and there were things that they needed to do in order to achieve their competencies. One was to fit in with the staff team and another was to get to know

the clients as quickly as possible. So they would end up short cutting the theoretical nursing process as fast as they could. So they were up and running very quickly. They would try to do this to an unnatural level really. It can take time to get to understand a patient properly. I mean, it can take some time to build the therapeutic relationship with the person. However, in the placement environment, there is sometimes an implicit expectation, that in order to demonstrate competence, they have got to be seen to be rolling their sleeves up and doing it. Spending time with patients may not be a priority in such a context”.

(Nursing Educator, Interview)

Add to this mix, the additional barrier of language discordance (Sobo and Seid, 2003; Sobo, 2004; Sobo and Loustaunau, 2010) between the student nurse and service user, then it may not be hard to envisage the attractiveness of the idea that culture can be reduced to a ‘technical skill’ (Good, 1995b). That is, a series of ‘do’s’ and ‘don’ts’ that define how to treat a person of a ‘given’ cultural background (Betancourt, 2004), and for which practitioners can be trained to develop ‘expertise’ in (Kleinman and Benson, 2006).

This ‘fact file’ approach is related to the concept of ‘culture specific competency’ (Fitzgerald, 2000). According to Fitzgerald (2000, p.185), this concept is concerned with:

“The ability ‘to participate in the everyday web of social relationships, even if at a limited or reduced level’ (Marshall, 1996, p. 250). It means ‘possessing a social intelligence inside and being able to express or communicate that intelligence in meaningful ways’ (Marshall, 1996, p. 252), and ‘having sufficient cultural knowledge, reasonable mental blueprints for culturally appropriate behaviour’ (Clement, 1982, p. 195), to pass (Goffman, 1959; 1963) ‘as an insider, as a real fictive member of a particular cultural group’ (Fitzgerald, 2000, p. 186). In this sense of the term, cultural competency is more in line with the way it is used in ethnoscience and, therefore, ‘culturally patterned behaviour and artefacts are but epiphenomena of this competence’ (Clement, 1982, p. 194).

To have insufficient cultural knowledge or to be unable to express that one possesses such knowledge is to be culturally incompetent and situates the person as an outsider, an impaired or disabled person, or even as a non-person (e.g., Armstrong and Fitzgerald, 1996; Fitzgerald and Armstrong, 1993; Ingstad and Whyte, 1995; Marsella and White, 1982-4; Marshall, 1996). To be viewed as culturally incompetent or even to believe that one is viewed as culturally incompetent (Fitzgerald, 1995; Fitzgerald and Paterson, 1995), can have a profound effect on a person’s concept of self and their behaviour. In mental health, culture specific competency is more often related to evaluations of a person’s mental status, by oneself or others, to determine whether or not a person is mentally ill or incompetent”.

To obtain this type of cultural competency requires an extensive period of socialisation, which few practitioners will have the time, skills, or opportunities to develop (Fitzgerald, 2000). Furthermore, student nurses are rarely assigned to monocultural or even bicultural placement settings, and therefore need to be able to work with service users from very diverse cultures and the diversity that presents itself within each cultural group. Thus, an exclusive focus on attaining culture specific knowledge will have “limited utility in most modern health care contexts” (Fitzgerald, 2000, p. 186). Such calls for ‘fact file’ (Gunaratnam, 2008) type knowledge, highlight a lack of understanding of contemporary anthropological conceptualisations of culture (Sobo, 2009), or at best, a restrictive understanding of culture as a materialist concept (Fitzgerald, Mullavey-O’Byrne, Twible and Kinebanian, 1995).

Summary

The primary issue to emerge from participants’ accounts of pre-registered mental health student nurses’ ‘multicultural clinical interactions’ (Fitzgerald, 1992), were the difficulties with distinguishing psychopathology from religious experiences, beliefs, and practices. This issue was related to the clinical anthropological concept of the ‘normative uncertainty’ evaluation dilemma (Good and Good, 1986). Determining the ‘falsity’ of hallucinations and delusions with religious content may prove to be a fruitless effort, as these phenomena are super-empirical and non-falsifiable. Rather, they should be viewed as existing on a continuum (Peters, Joseph and Garety, 1999; Peters, Day, McKenna and Orbach, 1999; Wiebe, 2004; Peters, 2010) and their clinical relevance needs to be assessed on a multidimensional basis (Pierre, 2001; Mohr and Pfeifer, 2009; Dein, 2012). Several of the participants situated the clinical concept of insight in the context of the ‘normative uncertainty’ evaluation dilemma. While ‘insight’ is typically used as a diagnostic criterion of schizophrenia (Endicott, et al., 1982), the student nurse participants’ narratives brought to mind the cultural critiques of this assessment measure.

Some of the participants felt that these assessment dilemmas were a consequence of their lack of cultural knowledge. In particular, it was difficult to evaluate the significance of religious phenomenology when the student nurse participant was unfamiliar with the range of normal religious beliefs and behaviours which existed in the service user’s culture. Mental health practitioners need at least to be made

aware of the kinds of religious issues that they are likely to encounter in practice, and also may require additional education about major religious teachings (Dein, 2004; 2010a).

Culture specific knowledge when presented in the form of 'fact files' (Gunaratnam, 1997; 2001; 2004; 2007) can privilege and separate cultural processes from individual and subjective experience (Dein, 2006a). How people respond to illness is marked by intra-cultural and inter-cultural variation (Lambert and Sevak, 1996). A cultural deterministic application of 'factfiles' in decision making around the 'normative uncertainty' evaluation dilemma may lead to the type of clinical assessment errors (Tseng and McDermott, 1981; Stein, 1985; Minas, 1990; Fitzgerald, et al., 1997a; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Stolk, 2009) documented in the following findings chapter. However, if cultural knowledge is used as an informative 'guide post' rather than as a culturally specific 'blueprint', it may help the student nurse to anticipate possibilities that should be considered, and make sense of phenomena that have already occurred (Galanti, 2008).

Chapter 6

Clinical Evaluation Errors and the Decontextualisation of the Service User's Experience

Introduction

In this findings chapter, I will focus on participants' reports about the assessment errors associated with the 'normative uncertainty' evaluation dilemma (Good and Good, 1986). Most of these 'critical incidents' (Fitzgerald, 2000) were about how culturally validated phenomenology was misinterpreted and/or reified as pathological phenomena, although other types of assessment errors were also documented. A core theme which linked these reported errors was the inability by some of the mental health staff in placement settings to assess service users' experiences in their local context. That is, practitioners appeared to be guided by a 'culture blind' approach (Fernando, 2002; 2010).

In the minds of the participants, the decontextualisation of service users' experiences was explained by poor standards of care, the cultural ideology of the placement setting, and the political economy of care. When discussing the cultural ideology of the placement setting, participants described instances where (usually religious) phenomenology which did not fit the clinical template of psychiatric medicine was either ignored or pathologised. The political economy of care was reflected in 'multicultural clinical interactions' (Fitzgerald, 1992) where there was language discordance (Sobo and Seid, 2003; Sobo, 2004; Sobo and Loustanaou, 2010) between nursing staff and the service user, and the cost and rationing of professional interpreter services led staff to avoid interactions with non-English speaking service users and to base their assessments on clinical observation alone. Thus, I reach a similar conclusion to Carpenter-Song (2011), who recently suggested that often it remains "the case that much of what mediates experiences and outcomes of health care falls outside of the dyadic interactions of patients and clinicians" (p. 180). Under such operative conditions, assessment errors and the decontextualisation of service users' experiences had negative impacts on the standard of care and the appropriateness of psychiatric treatment.

The Clinical Implications of Assessment Errors

The problems presented by the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) can have important clinical implications (Tseng and McDermott, 1981; Stein, 1985; Westermeyer, 1987; Minas, 1990; Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997; Fitzgerald, et al., 1997a; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Vega, et al., 2006; Stolk, 2009), in that the failure to appreciate the role of culture on the expression of distress may result in one of the following six assessment errors.

- Assessing cultural variations in phenomenology as psychopathology (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997). Although the experience is evaluated as being 'abnormal' by an outsider, it is seen as being 'normal' in its local context (Tseng and McDermott, 1981).
- Assessing the signs and symptoms of psychopathology as cultural differences (Stein, 1985). Although the experience is regarded as 'abnormal' in its local context, it is viewed as being 'normal' by an outsider (Tseng and McDermott, 1981).
- The nature of psychopathology is misdiagnosed (Minas, 1990; Stolk, 2009).
- The severity of psychopathology is underestimated or overestimated (Minas, 1990; Andary, Stolk and Klimidis, 2003).
- There is a failure "to appreciate the significance of psychopathology to the patient and the patient's family" (Minas, 1990, p. 276).
- There is a failure "to detect psychopathology" (Minas, 1990, p. 276).

The majority of participants' 'critical incident' narratives that were about these kinds of assessment errors, focused on how culturally accepted phenomenology was misinterpreted as evidence of psychopathology. However, in the following short story, the student nurse participant talks about how culture, or more specifically religion, can be what Stein (1985) described as a 'red herring' in clinical decision making and assessment. The cultural and religious background of the service user may exert a 'patho-plastic' effect on the manifestation of the illness (Tseng, 1997; 2001; 2003; Tseng and Streltzer, 2008). This leads to the danger of assuming it is a cultural issue, when in fact, it is an issue of psychopathology (Dein and Lipsedge, 1998).

“It is hard to see where the illness comes in and the cultural...Because things that I may find a bit strange....maybe, just be normal for a different culture, whereas, it could be their illness. So it could mean that you can miss the illness, because the patient’s religion can confuse the illness somewhat. So a patient’s expression of religious beliefs may be misleading in certain cases and could confuse the picture about their illness”.

(Female 3rd Year Student, Interview)

To put the central theme of this narrative another way; “while culture is an important part of all clinical interactions, it is only one possible explanation of problems and dissatisfactions” (Fitzgerald, 1992, p. 6-7).

As is evident in the next narrative, cultural idioms of distress (Nichter, 1981) may confuse and complicate nursing assessments, leading to possible misdiagnosis and the wrong pharmacological treatment.

“It was certainly a bigger issue where I used to work down in London. It was a bigger issue there as the client population was so diverse. We used to work with a lot of service users who were asylum seekers. Many of them were completely culturally dislocated and the undergrad students would find that very hard to get their heads around. I think they struggle when trying to understand the different cultural experiences and different manifestations of distress that they encounter during their clinical placements. I can think of an example of that when the students were working with Sri Lankan clients who were experiencing ‘Koro syndrome’. In the case of ‘Koro syndrome’, the sufferer believes that their penis is shrinking back into their bodies. Anyway, the students would really struggle with that. They were uncertain about how they should deal with that or how that should be assessed. They could not really understand why it was not a psychotic disorder, because they felt it was very much in line with psychosis. So everyone was saying; ‘well that’s delusional; he’s obviously psychotic’. So trying to explain to the students that ‘Koro syndrome’ was actually a cultural manifestation of loss and depression for Sri Lankan men was quite difficult.

And that was a really interesting case, because the only reason it came to light in this day and age where you do not have the time to research every single case and symptom, was that we had a psychiatrist who was from Sri Lanka. So he translated for us when we were interviewing the patient. And some of the students had been helping to look after this guy for a few weeks. He was being treated at the time with anti-psychotic medication, as it appeared from his symptomatology that he had a presentation of psychosis. He was on a very high dose of olanzapine. However, the psychiatrist said to us that ‘you have interpreted it completely wrong’. So once he had re-diagnosed the illness, the treatment changed. The psychiatrist had said that the anti-psychotics would not help this person and that we should try treating him with anti-depressants. The gentleman in question then did get better and I think we had a much fuller understanding of the patient’s condition”.

(Nursing Educator, Interview)

The data seemed to reveal a couple of related reasons for these assessment errors, all of which are covered in this findings chapter. However, the core theme which linked all these factors was the inability by some staff in student nurses' placements to consider phenomenology in its local context. The imposition of 'etic' (Skultans and Cox, 2000) categories of 'disease' without due appreciation of 'emic' and 'illness' (Eisenberg, 1977) perspectives, was a feature of many narratives. Although a few of the student nurses accepted that reductionist practice was an inevitable product of the professional or ward culture and/or political economy of care, most of the students desired a more person-centred style of care.

In terms of a prevailing professional culture, it was frequently suggested by the participants, that where the experience of the service user did not fit the clinical template, it was ignored or pathologised. This issue was raised particularly in the context of service users' religious beliefs and experiences. These findings resonated with much of the history of psychiatry (Freud, 1961a; 1961b; Group for the Advancement of Psychiatry, 1976; Ellis, 1980; 1986; American Psychiatric Association, 1987); most published psychiatric texts (Neeleman and King, 1993); and the majority of the mental health nursing literature (Oldnall, 1995; 1996; Fry, 1998; Martsoff and Mickley, 1998; Swinton, 2001; Malinski, 2002). In the strict biomedical framework, only data that is observable and verifiable is counted and deemed relevant (Andary, Stolk and Klimidis, 2003; Stolk, 2009). Non-corporeal phenomena are not seen of relevance to the psychiatric interpretation of the service user's experience, other than as an indication of psychopathology (Kirmayer, Young and Robbins, 1994; Pilowsky, 1997). Natalie Tobert (2007) notes that concepts which fall outside the boundaries of this positivistic belief system are considered to be "other people's beliefs" (p. 5), which are viewed as irrational and not part of material reality. Similarly, Byron Good (1994) suggests that the use of the term 'belief' has connoted "error or falsehood" (p. 17), whereas, the term 'knowledge' is associated with 'correct explanations'. These issues were highlighted in the next critical incident.

"I can think of one particular situation which arose for me when I was working on one of the acute wards. We had a lady who came onto the ward after she was sectioned. Anyway, the staff on the acute ward were querying whether she was really seeing things and if she was psychotic. This lady was a very lovely and quiet person. She was a black lady in her early 60's. She was adamant that she was not seeing things

like a person with a psychosis would see things. However, she kept referring to something. There were other things that made the nursing staff query whether this lady had psychosis. Anyway, from day one this lady was adamant that it was not to do with anything psychotic. She could see this person there and whether she was, it was always there. According to this lady, it was with her when she was on the ward. It was also with her when she was at home. When we delved into it further, it became apparent that this person or presence was not a psychotic delusion, but connected to her culture and religion. She disputed the section as well. She won the tribunal, because this presence was linked back to her religion and culture. This presence was not part of any psychotic delusion or hallucination.

Anyway, the presence had initially been misinterpreted as evidence of psychosis. It was the reason why she was sectioned. This initially seemed to overshadow everything else, such as her religious and cultural beliefs. Though, it became evident from talking and listening to her that this presence was part of her culture. She was obviously upset about being sectioned on an acute ward. This lady had never been sectioned before. So it must have been a horrific thing for her to find herself in that position. I think everything else, such as her religious beliefs got lost in translation. As everybody just seemed to focus on the fact that she kept on seeing something. They did not realise that what she was seeing was to do with her religious beliefs. This lady was adamant that she did not want treatment, because she did not perceive that she was ill. Then I said to the other nurses on that ward; 'well hang on a minute, let's look at her cultural background'. I mean, she was very religious, as she liked to go to the church every Sunday. By listening and talking to her, we found out that this presence was linked to her religious background. What they class as 'normal' presentation psychosis was not apparent in this case. As I say, we took it further and we researched the background of this lady.

I think she was very upset that basically her whole belief system was being challenged and undermined, and her voice was being denied. And of course you are administering her medication, which she did not need. But when she realised that we were there to listen and we were there to fight for her, she started to engage with us. There does seem to be an assumption in mental health that just because somebody has been admitted onto a ward, they must have a mental illness. It is trying to get out of our own fixations, by realising that not everyone who is admitted onto a ward has a mental illness. It could be the case that the patient's behaviour has been misinterpreted by the mental health team".

(Female 2nd Year Student, Interview)

This narrative and other 'critical incident' accounts highlighted the assessment errors and clinical implications that can result from the failure to adequately consider the role of culture in mental illness. In particular, they show that the misattribution of culturally accepted experiences as psychotic phenomena may lead to involuntary and "unnecessary treatment with antipsychotic drugs, with all the negative consequences of such treatment and the negative personal and social consequences of a psychotic diagnosis" (Minas, 1990, p. 276). As Minas (1990, p. 276) explains, "overdiagnosis, underdiagnosis and incorrect diagnosis can all have a

significant impact on the appropriateness of the treatment advice given and its effectiveness, and on the course and outcome of the patient's illness". It also has been shown that the misinterpretation of the severity and significance of phenomena such as suicidal ideas in cross-cultural situations, can have unintended, but lethal consequences (Sabin, 1975).

These narratives reveal that the religious identities of service users were effectively being challenged and undermined, and research has shown the profound isolation which service users may experience when their religious identities are invalidated by mental health professionals (Minas, 1991; Lukoff, Lu and Turner, 1996; Kilshaw, Ndegwa and Curran, 2002). Mohr and Pfeifer (2009) note that the labelling of supposed delusions "as 'religious' often leads to an attribution of pathology to the spiritual and religious life of patients", and such "labelling is indeed stigmatizing" to the service user (p. 92). Yet many service users draw on their religion to cope with the distresses and consequences of mental illness (Meador, et al., 1992). A person's religion may be an integral part of how they view life, of how they relate to others, and may be a source of that person's core beliefs and values (James, 1961; Browning, Gobe and Evison, 1990; Krippner and Welch, 1992). The invalidation of a service user's religious identity, therefore, can lead to adverse outcomes, such as blocking any future attempts at help-seeking (Stolk, 2009).

Male Student: *"Could it then be argued that religion could be a protective factor for somebody at suicide risk, then? And then there is a problem if the nursing staffs discredits that person's beliefs, or sees it as part of their illness. You know? If somebody has got this strong religious belief and that is what is supporting them and they think, well okay, it's a bit hard right now, but God will help me see my illness through. And then the nursing staffs on the ward turn around and try and take that off them. We are then taking away that protective factor from that person. That is a really big risk in nursing practice, I think".*

Female Student: *"Yes, I agree with that. By doing that you are effectively taking away something that means a lot to a person by discrediting it".*

(Pre-Registered Mental Health Student Focus Group N 1)

Calabrese (2011) notes, from his recent research into the 'culture of medicine' and patients' perspectives on psychiatric treatment, that a single negative experience with mental health services can be "transferred to an entire institution or to the process of seeking psychiatric services generally" (p. 190).

This decontextualisation process was not restricted to the issue of religion. Participants also described cases where what appeared to be a 'normal' and personal lifestyle choice of the service user was fitted into a clinical and diagnostic template. Once again, these 'critical incidents' underscored the need to assess the person's behaviour in its local context.

"There was a lady who was admitted to the older adult acute assessment ward where I am on placement at the moment. She was admitted to the ward with what seemed to be acute anxiety and clinical depression. The struggle that I found when doing her admission and going over her care plans.....Was that again, from the cultural angle for this lady.....It was normal.....I don't like that word normal, but for her, it was normal to stay in bed until 11 o'clock or 12 o'clock even. And then she would get up to have her breakfast. I think her day was quite staggered. She would probably have a little tea in the evening and she would not go to bed until really late.

I found that it was really difficult to try and get her to settle in on the ward, because on a ward, I suppose it is thrust on the patient the routines and rules. And it is very much like; 'come on, we have got to do the bed and breakfast is ready'. If they don't have breakfast or don't get out of bed, it is immediately documented. They are refusing to get up and they are refusing to eat so we must keep an eye on them. I know it is easier said than done, but people do have different lifestyles, and I think they should be looked at more holistically. I don't always see it as a problem if they do not want to get up at 7 o'clock in the morning. It is just the way that some people live and I think we have got to respect these lifestyle differences and try to incorporate that into practice.

So in that case, her behaviour of getting up late in the morning and not going to bed until very late was perceived by the nursing staffs as being an 'abnormal' lifestyle. For instance, it was documented that the patient had 'management difficulties', because she refused to get out of bed until 12 o'clock. Yes.....Yes she was admitted for acute anxiety and she had the symptoms of a slight depression. And sleeping a lot and not getting out of bed until late is a normal feature of clinical depression. But if you actually went over this lady's case history and actually talked with her that was the lifestyle she led and was used to. So for me, it was not a 'management issue'. It was rather the patient's choice, and that is something that she has continued to do over a long period of time. But what they fail to realise is that they were not looking at her behaviour in a holistic sense. If it is this lady's lifestyle, I believe that it is not therapeutic at all to put these sorts of demands on her. I believe it can be quite detrimental to their mental health by trying to get them to do things that they don't normally do and what they don't want to do".

(Female 3rd Year Student, Interview)

Perhaps, it should not be surprising that the service user's behaviour was matched and evaluated against psychiatric diagnostic criteria. Although mental health nurses do not make formal diagnoses, their clinical practice will often be informed by an internalised diagnostic framework based on psychiatric nosological criteria (Andary,

Stolk and Klimidis, 2003). Nurses may find it extremely difficult to cast off the shackles of this framework. Since most of their training, most of their evidence based practice, most of the published research and most mental health team communications are underpinned by the 'universalistic' diagnostic criteria of psychiatry (Stolk, 2009). As Andary, Stolk and Klimidis (2003, p. 2) have written, the majority "of what currently is known about psychopathology, and about what are considered to be specific categories of mental disorder, is drawn from research that is conducted with Western notions of what constitutes normality and abnormality and what constitutes disorders such as schizophrenia and major depression". Various scholars have noted, that until relatively recently, the clinical training of mental health practitioners has tended to dismiss alternative models for understanding and treating mental distress (Sue, et al., 1982; Westermeyer, 1985; Myers, Wohlford, Guzman and Echemendia, 1991). Rosenhan's (1973) seminal study perhaps provides the most illuminating and famous example of reductionist clinical decision making in action, where once labelled, the patient's every action is judged as being insane. Even the writing behaviour of the pseudo-patients in Rosenhan's experiment was perceived to be an aspect of the patient's supposed mental illness.

Language Discordance and the 'Culture Blind' Approach

The cultural psychiatrist Suman Fernando (2002; 2010) has written about the existence of a 'culture blind' approach in the provision of mainstream mental health services. In nursing practice, the 'culture blind' approach denies the important role that culture plays in the assessment, care and treatment processes (Robinson and Elkan, 1996; Vydelingum, 2000) and furthermore, raises questions about uneven power relationships and ethnocentric clinical practice (Puzan, 2003; Cortis, 2004; Thom, 2008). The assumption "that being 'blind' to something nullifies its effects or significance" is a "serious fallacy" (Fernando, 2002, p. 135). According to Fernando, two negative effects on clinical practice derive from the 'culture blind' approach. First, the service user's experiences are seen out of context, in that, s(he) is not seen as a "part of a society or a group, with, for example, allegiances and hostilities towards other people, influenced by other people and dependant on a wide circle of people for what s(he) is" (Fernando, 2002, p. 132). Secondly, any differences that the service user presents are likely to be assessed as individual differences-that is,

assessed in terms of their deviance from a generalised 'norm', rather than something that is seen to reflect the service user's upbringing and experience. As Fernando explains, the 'culture blind' approach falls into the trap of denying the reality of culture.

It became apparent from listening to the 'critical incident' stories of participants that the 'culture blind' approach seemed to be particularly connected to, although not limited to, acute care contexts where there were issues of 'language²⁶ discordance' (Sobo and Seid, 2003; Sobo, 2004; Sobo and Loustau, 2010) between the nursing staff and service users. In the opinion of the participants, the failure to adequately deal with the issue of 'language²⁷ discordance' led to inferior and poor nursing care and the inability to assess service users' experiences in their context. The problems arising from the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) in mental health student nurses' clinical placements were thus exacerbated.

"I had a Chinese lady on clinical placement that I and a colleague were working with and whose family saw her mental illness as a sign of the devil's work. At dinner times, she wasn't allowed to sit with the rest of the family because of what the rest of the family believed about her illness. I was with the early intervention team and we suddenly noticed that when we took her out with us, she would not eat with us. She seemed to become very self-conscious of eating food around us. And at the time, we did not yet have the information about the family's beliefs about her illness and the impact it had on her at meal times. So myself and the early intervention person were just putting it down to like; 'oh why is she not taking the medication? She is on the

²⁶ 'Language' involves any set or system of symbols, which used in a more or less uniform fashion, enables people to communicate intelligibly with each other (Macquarie Dictionary, 2009). Furthermore, language can be translated into speech, the written word, and signs, and is the main mode used to convey and receive messages (Gudykunst and Ting-Toomey, 1988). As Fitzgerald and colleagues' (1997a) note, just as every person is a member of a cultural group and community, each person knows (with very few exceptions) a language and belongs to a language speaking community. The concept of language is included in the broader concept of 'communication' (Fitzgerald, et al., 1997a). Human communication encapsulates the creation and exchange of messages that use any mode or channel, across a range of situations that may or may not involve face-to-face interaction (Fromkin, Rodman, Collins and Blair, 1988; Halliday, 1989; Bonvillain, 1993). In face-to-face interactions ('interpersonal communication'), communication "is primarily dependent upon verbal and non-verbal channels, but other modes may also be involved, for example, written and graphic representations" (Fitzgerald, et al., 1997a, p. 102). A shared knowledge of a language system allows for the exchange of information, ideas, emotions, feelings, and experiences-phenomena that all are important to mental health practice (Fitzgerald, et al., 1997a).

²⁷ The service user's level of psychopathology can affect English language proficiency (Oquendo, 1996). A service user who speaks English fluently when well or in recovery, can revert to their first language during a psychotic episode (Stolk, 1996). This is important to bear in mind, as in the field of mental health; the content and style of communication are frequently used as indicators of psychopathological status (Fitzgerald, et al., 1997a).

anti-psychotic drugs and that should be making her feel hungry and wanting to eat'. So I was discussing with my colleague about the reasons why she was not eating with us.

And then we started to make mistaken judgements that it may have been to do with her illness...And anyway, it turned out that because her family believed the devil had kind of come upon her, she wasn't allowed to sit with them at the dinner table. She felt like she could not eat in front of us and that she had to eat in secret. She couldn't eat in front of other people. But we were making wrong kinds of judgements about her behaviour. And that was also to do with the fact that we could not directly communicate with this Chinese lady. She only spoke very little English. So it was very hard to understand what exactly was going on with her anyway. So you had to kind of piece bits together and make a jigsaw, but the jigsaw didn't always match-if you've got me? So how do you avoid making misjudgements when there are those evident language difficulties with the patient"?

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

"There was no one there on this functional and elderly ward who spoke any Polish. It was also the first time that I had been on that ward for one of my third year placement experiences. The other nursing staff members recommended trying to use prompt cards to communicate with this patient who could only speak Polish. I had tried to use prompt cards to communicate with this patient but they had not worked. Furthermore, the prompt cards may not capture the obvious variations in the use of Polish. The communication barriers made it extremely difficult to develop any sort of therapeutic relationship with this person. It felt like you were getting nowhere with this patient. She was not going to get better here on the ward if she could not communicate with any of the nursing staffs.

I also did not feel that anything was being done by the nurses on that ward to facilitate communication with this patient. I think the mental health trust had contacted the patient's family in an attempt to facilitate communication with her. But is it really appropriate in that context to use the family as a means of establishing communication with the patient? Are they interpreting what we were saying to her correctly? Furthermore, were they interpreting what she was saying to us correctly? I think that was a massive issue to deal with, especially when you are dealing with matters of nursing assessment. I do not think the trust was willing to get an interpreter in to effectively communicate with this lady. The trust is always thinking about things in terms of cost and savings. They want to know how long you are going to have the interpreter in for. Are you going to use the interpreter all day and every day? So in this case, it was very difficult to attend to even her basic physical needs. She could not even understand something simple like; 'do you need the toilet, or do you need to use the bathroom'?

I think it was also difficult to determine what her illness actually was, because of the communication barriers. You could not understand anything that she was actually saying to you. She was unable to communicate how she was feeling to you. I think the other nurses had used prompt cards, but had given up on using them. It was almost like as if they were not performing their duty of care to this person. They had no plan of care and had no idea of what to do with this patient. So she was just sitting there on her own. It was hard to work out whether she was distressed, as in some

languages, you have a high pitch tone and shouting may be considered normal. It does not necessarily mean that because they speak in a high pitch tone they are distressed. It is hard to understand that if they do not speak the same language as you. So it is very difficult to tell if they are distressed and if they are distressed-you may fail to understand what they are actually distressed about”.

(Female 3rd Year Student, Interview)

Assessment and treatment modalities are usually based on the assumption that service users have a basic level of facility in the English language, and furthermore, understand the local cultural and social context (Fitzgerald, et al., 1997a). The political economy of care (Bullon, Good and Carpenter-Song, 2011; Calabrese, 2011; Carpenter-Song, 2011; Willen, 2011b) was reflected in student nurse participants accounts about the prohibitive cost and/or rationing of professional interpreter services to formal aspects of psychiatric assessment and consultations. Multiple policy recommendations and reviews, such as ‘Inside Outside: Improving Mental Health Services for Black and Minority Ethnic communities in England’ (Sashidharan, 2003), and more recently, the Department of Health’s (2005) ‘Delivering Race Equality in Mental Health Care’ five year action plan, have set out the case for more accessible interpreter services and the need for mental health professionals to be trained in the effective use of these services; yet the findings of this PhD research showed that at least the former does not appear to be happening in mental health student nurses’ clinical placements. Thus, barriers to communication and assessment at the inter-individual level “cannot be separated from organisational contexts and service mechanisms which play a far reaching part in shaping individual experiences” (Robinson and Gilmartin, 2002, p. 462).

In such circumstances, the student nurse participants mentioned that they and their nursing colleagues resorted to seeking the advice and interpretation ‘skills’ of the service user’s family members where language barriers prevented direct communication with the service user. The accuracy of the family members’ advice was questioned and the ideal of maintaining the service user’s confidentiality and privacy was undermined in these instances. Indeed, as Moreno, Otero-Sabogal and Newman (2007, p. 331) highlighted, “interpretation is a learned skill; whereas it is true that every interpreter can speak at least two languages, it does not follow that every bilingual person is an effective interpreter”. Research indicates that the use of ad hoc interpreters can result in an increase in clinically consequential errors (Flores, et al.,

2003) and undermine standards of good clinical care (Baker, Hayes and Puebla Fortier, 1998). Ad hoc interpreters may be “prone to omitting, adding, substituting and volunteering information” (Willen, 2011b, p. 72). The nursing researcher Natasha Thom (2008, p. 1206) points out that whether “the decision to limit the communication is deliberate or not, nurses could be found guilty of ethnocentrism. By not offering an interpreter service to the patient, the nurse is denying the patient an opportunity to speak in their own language within the context of their culture”. Adequate nursing assessments rely on (cultural) linguistic as well as clinical competencies (Bradby, 2001). As Culley and Dyson (2010, p. 46) explain; “clinical care can easily be compromised without adequate language support: a proper history cannot be taken; symptoms or problems can easily be missed or misinterpreted; expensive and unnecessary tests can be carried out; inappropriate treatments may be prescribed; and patient adherence may be reduced”.

Clinical observation²⁸ is an important and integral component of mental health nursing assessment (Barker, 2004; Plant and Stephenson, 2008; Ryrie and Norman, 2009), but the findings of this PhD research revealed that where the service user was unable to/or had difficulties with speaking English, the nursing staff in clinical placement ward settings were relying on this mode of assessment alone. Such a mode of assessment is likely to be heavily influenced by a clinical and diagnostic (‘etic’) template (Stolk, 2009), and may lead to ‘depersonalisation’ (Lelliott and Quirk, 2004; Quirk and Lelliott, 2004) and the failure to consider service users’ experiences in their local context. Not only does such reductionist practice exacerbate the difficulties presented by the ‘normative uncertainty’ evaluation dilemma, but ‘category fallacies’ (Kleinman, 1977; 1988a) and the aforementioned clinical assessment errors (Tseng and McDermott, 1981; Stein, 1985; Minas, 1990; Fitzgerald, Mullavey-O’Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-

²⁸ According to Ryrie and Norman (2009), clinical observation “is a continuous form of data collection” (p. 220) that forms an important part of mental health nursing assessment. Clinical observation can be relatively informal, by involving an evaluation of the service user’s appearance, behaviour and interactions (Ryrie and Norman, 2009). By contrast, structured clinical observation involves the use of pro-formas, which are usually completed by the nurse, but in some cases, are completed by the service user. Another type of clinical observation that is used by mental health nurses is concerned with documenting biochemical and physiological indices (Barker, 2004; Plant and Stephenson, 2008).

O'Byrne, Clemson and Williamson, 1997; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003) were more likely to occur.

“But in the case of assessing her symptoms, because this patient could not speak any English, it was a lot harder to do that. The nursing staff on that acute assessment ward would mainly assess her symptoms by clinical observation. They tended to avoid finding out from the lady why she would do certain things. And if they wanted to find out about the reasons why she was doing certain things or about aspects of her culture, they would not ask the lady, but her family members, who could speak some English. It became apparent that she would only drink boiled water, but she also had a psychiatric history of self-harm. So it was very much like; ‘shall we allow her to get the hot water herself’? She let it cool down a bit, but she never drank cold water while she was on that ward. And that was quite.....So I think the communication problems meant that the staff did not really develop a proper therapeutic relationship with this lady. It was very much like; ‘hello how are you’, and that was it really. It was not as in-depth as it would be with a patient where English was their first language. I think that most of the nursing staffs just gained most of their information about this lady from her psychiatric history, which was recorded in her clinical case notes, or by consulting with the family members who could speak English.

But as a student, you just get a lot more time to spend with a patient and to see them more as a person, rather than just as an ‘illness’ or ‘diagnostic category’. So the nursing staffs were monitoring her behaviour and when they needed some more information, they consulted with her family or her case notes. The problem there was that they were not asking her about how she was feeling and therefore, it was based more on a subjective opinion of how she was feeling at the time, or why she was acting like that. And we had no information from the lady about her culture or anything like that. So it was useful to have access to the interpreter when the nursing staffs could, as we may have been getting inaccurate information about her culture and illness from the family members”.

(Female 2nd Year Student, Interview)

“I have just finished working in an older adult functional assessment ward with clients who were suffering from functional disorders such as psychoses and schizophrenia. Anyway, I will describe my experiences of working with two patients on this unit, one of whom was Polish, and I believe the other patient was from India. There are lots of different angles from which I can talk about, in terms of how the staff worked with these two patients. The first definite issue that occurred to me was that the nursing staffs were quite reluctant to actually communicate with these two patients. They were quite reluctant to go into these two patient’s rooms and communicate with them. From my observations of the nursing staff, I noticed that they were looking through the window of these patient’s rooms to assess what they was like, rather than actually interacting with them. I think that the nurses did not want to interact with these patients, because of the perceived difficulties with understanding their dialects and the language barriers. It was as if they did not want to get involved in that, because they had other things to do. So that was the first thing that occurred to me. Communication is such an integral part of nursing and especially, mental health nursing. It runs through everything we do in the nursing process. In mental health

nursing, being able to communicate effectively with patients is vital, especially where physical signs and symptoms are not so apparent. In mental health nursing, we use the communication process to understand everything from assessing a person's condition to issues around treatment".

(Female 3rd Year Student, Interview)

Many of the service users in Kilshaw, Ndegwa and Curran's (2002) London based ethnography of the conflict which existed between mental health professionals and black service users, complained that the clinicians based their assessments just on the clinical observations of mental health nurses. The clinicians therefore did not try to understand service users' perspectives or points of view. One of the service users reported that none of the psychiatrists on an acute assessment ward had ever actually spoken with her, and she was confused about how they could have assessed her properly.

As the student nurses in this PhD study witnessed, verbal communication is vital and intrinsic to holistic nursing assessment (Murphy and Clark, 1993; Gerrish, Husband and Mackenzie, 1996; Baldonado, et al., 1998; Kim, 1998; Gerrish, 2001; Robinson, 2002; Ozolins and Hjlem, 2003; Gerrish, Chau, Sobowale and Birks, 2004; Cioffi, 2005; 2006; Lundberg, Backstrom and Widen, 2005; Jirwe, 2008; Jirwe, Gerrish and Emami, 2010) and the philosophy and practice of person-centred care (Reynolds and Cormack, 1990; Gerrish, 2000; Vydellingum, 2000; 2006; Peckover and Chidlaw, 2007; Perget, 2008; Pergert, Ekblad, Enskar and Bjork, 2007). According to some of the participants, where the service user was unable to/or had problems with speaking English, nurses were even minimising or avoiding interaction with the service user. A few of the participants suggested that this avoidance was a reflection of nurses' anxieties with their own communication deficiencies, while others mentioned that nurses' interactions with non-English speaking service users were constrained by the competing demands on nurses' time. One participant even suggested that the practice of avoidance was possibly down to 'laziness'.

"And it relates back to some of what I was saying earlier in this discussion about how the nurses and students manage their anxiety when differentiation issues between religion and mental illness and language issues are apparent. That it can seem a natural way to manage anxiety or the feeling of being uncomfortable. That is, the best way would be to avoid it. So it's within that kind of framework".

(Nursing Educator, Staff Focus Group)

Male Student 1: *“I don’t know....And I think it is a flaw of me if you like. And I keep thinking I’m going to change and do differently, but I don’t. And I’m always guilty of this on wards and I don’t know if everybody else is the same? I mean, you sort of latch on to the more approachable and more easy to handle patients. You build a rapport with them. What I mean, is the patients you can hold those conversations with and where you do not have the communication barriers. And then the ones who perhaps, you think there is a language barrier or a cultural barrier you tend to stay away from. Whether I do it consciously, subconsciously, or just out of laziness, I do not know? And then I suddenly find myself thinking; I’ve been here two weeks on this placement and I haven’t said hello to this guy and I don’t know much about him. And I think that sometimes, I am guilty of that as a student nurse. I don’t know if nurses are guilty of it also? I don’t know if all of students are? I know that I’m guilty of doing that”.*

Male Student 2: *“Yes...You know? Line of least resistance and going for the patient that is easier to interact with”.*

(Pre-Registered Mental Health Student Focus Group N 1)

“I can honestly say that it puts you in a difficult position when you are trying to deal with assessment and cultural issues and there are language barriers with the patients. It questions your role as a student nurse, due to the difficulties I had in understanding and communicating with these patients. It really unsteadied you in your role, because it was really difficult to understand what they were saying and you were trying to go in their rooms, do your observations, do your job, and be efficient at the same time. Obviously, I did go and try and talk to these patients, but at the same time, you are trying to balance these demands on you as a nurse. We were told in a lecture recently that you can be efficient, effective and compassionate nurses all at the same time. However, in liveable reality, constraints on time, when you have those communication problems, limit how person-centred you can be with your patients. So you can’t spend the amount of time that you require to address a particular person’s needs. We do not have the time or the resources to give somebody what they need. So that is very frustrating”.

(Female 3rd Year Student, Interview)

The sociolinguist and health services researcher Anne Pauwels (1995) suggests that there has been a tendency in the health professions “to ask fewer questions of and to say less to patients who do not speak English than is the case with their English speaking patients” (p. 45). ‘Inexperience’, ‘anxiety’, ‘fear of the unfamiliar’ (due to an unfamiliarity with cultural differences), and ‘disempowerment’ have all been identified in the academic literature as reasons for practitioners minimising contact and limiting communication with service users with limited or no facility in the host country’s language (Pauwels, 1990; 1995; Kai, et al., 2007; Peckover and Chidlaw, 2007; Shahnavaaz and Ekblad, 2007; Jirwe, 2008; Jirwe, Gerrish and Emami, 2010). The consequences of such an avoidance strategy can be serious. Assessment errors

(Tseng and McDermott, 1981; Stein, 1985; Minas, 1990; Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Stolk, 2009) followed by inappropriate treatment and management is the result of the failure to consider the service user's perspective. Shahnavaaz and Ekblad's (2007) focus group study of Swedish interprofessional psychiatric teams found that staff members avoidance of non-Swedish speaking service users, led to these service users being offered less time for psychiatric consultation and investigation. In such circumstances, adherence to prescribed psychiatric treatment may be adversely affected due to the service user receiving minimal, if any, information about what is perceived to be wrong with him or her (Pauwels, 1995). This in turn creates unnecessary anxiety, and thus the service user is then unlikely to take the necessary steps to manage their condition.

The 'critical incident' narratives presented in this findings chapter has shown that the cultural ideal of 'person-centred' care was shattered in student nurses' clinical placements. In particular, participants mentioned that service users with limited or no English language proficiency were unable to communicate their concerns and distresses with mental health staff. The result was that these service users were left isolated and alone in psychiatric wards. Similar issues were highlighted in Vydellingum's (2000) qualitative study of non-English speaking Hindu and Muslim patients in an acute care context in the south of England. In particular, the patients reported feeling that they were just 'passing through', were 'alone in a crowd', and 'trying to fit in' with a culturally alien place. The 'alone in a crowd theme' revealed the extreme loneliness and isolation felt by these patients. This feeling of isolation was reinforced by the sense that nurses were often too busy to respond to patients' need for information about assessments, diagnoses, and medication. Some of the patients even reported having to rely on their English speaking carers at visiting times to convey their concerns to the nursing staffs. Likewise, Jirwe, Gerrish and Emami's (2010) qualitative interview study of Swedish based student nurses' experiences of intercultural communication showed that where there was no shared language, the service user was unable to convey their sense of distress to the student nurse. Subsequently, the student nurse was then only able to speculate as to what was the

source of the service user's distress, and was therefore unable to provide appropriate support.

Summary

Misunderstanding the role and significance of culture in mental illness was connected to an inability by practitioners in clinical placement settings to evaluate the experiences of service users in their local ('emic') contexts. Both the political economy of care and/ or the cultural ideology of the primary medical system negatively impacted on appropriate clinical assessment and standards of care. The reductionist assessment practices, which were documented in participants' accounts, clearly conflicted with the meaning centred anthropological perspective that "tries to see people in context to better understand their experience of illness"(Kilshaw, Ndegwa and Curran, 2002, p. 8). The tendency to view 'others' from the dominant lens of one's culturally normative standards raised questions about uneven clinical power relationships and a 'culture blind' and ethnocentric approach to practice (Fernando, 2002; 2010; Thom, 2008). I will expand on these findings in the following two chapters, by further exploring how the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) was dealt with in preregistered mental health student nurses' clinical placements.

Chapter 7

‘Dealing’ with the ‘Normative Uncertainty’ Evaluation Dilemma: Outcome Criteria and Other Strategies

Introduction

This is the first of two findings chapters which explore how the ‘normative uncertainty’ evaluation dilemma (Good and Good, 1986) was dealt with in pre-registered mental health student nurses’ clinical placements. These chapters, therefore, are more orientated although not exclusively to the second research question. As the ‘normative uncertainty’ evaluation dilemma was the most central issue to emerge from self-reports of students’ clinical placements, it should not be surprising that participants talked at length in the interview and focus group sessions about how this issue was attended to in clinical practice.

In this chapter, I describe strategies that the participants reported, which bore some resemblance to what the academic literature has defined as the criterion of ‘outcomes’ (Jackson and Fulford, 1997). The participants’ seemed to focus on three dimensions of the criterion of ‘outcomes’-the ‘impact on functioning’, ‘the assessment of risk’, and the ‘emotional valence’ of the service user’s experience. Their utility in the differentiation of psychopathological phenomena from religious/culturally sanctioned experiences has been debated in the academic literature (e.g., Sims, 1992; Pierre, 2001; Siddle, Haddock, Tarrier and Faragher, 2002; Koenig, 2007) and I contextualise participants’ narratives by drawing on this literature. Two other strategies were also mentioned by some of the participants and they are dealt with in the latter sections of this chapter. These two strategies were categorised in the thematic analysis as ‘relying on intuition’ and ‘religious coping and psychopathology’. First, I outline a definition of the criterion of ‘outcomes’.

The Criterion of ‘Outcomes’

The criterion of ‘outcomes’ is perhaps the most commonly cited strategy for differentiating psychotic phenomena from religious phenomenology (Dein, 2010b). In Eeles’ research (Eeles, 2001; Eeles, Lowe and Wellman, 2003), the nurse participants used the criterion of ‘outcomes’ to refer to “the events or changes to the

individual which occurred as a result of the experience” (Eeles, Lowe and Wellman, 2003, p. 200). Furthermore, it is suggested that negative as opposed to neutral or positive outcomes indicate psychopathology (Jackson and Fulford, 1997). Both religious and psychotic experiences are considered to be the product of stress or ‘existential crisis’; but if the person gains insight and uses it to solve the initial problem, the experience will be self-limiting and non-pathological (Jackson and Fulford, 1997). Psychotic illness is “generally seen as detrimental to the life course”, whereas, a religious experience is viewed “as life enhancing and generally adaptive” (Dein, 2010b, p. 537). On the other hand, many people have evaluated their psychotic experience “as part of a process through which they reached, from their perspective, a constructive spiritual reorientation” (Jackson, 2001, p. 183). In this study, participants’ accounts focused on three criteria of ‘outcomes’-the ‘impact on functioning’, ‘the assessment of risk’, and the ‘emotional valence’ of the experience.

Criterion of ‘Function’

Many of the student nurse participants stressed the importance of assessing the service user’s level of function in different aspects of their lives. When a service user’s behaviour had a negative impact on activities of daily living, psychopathology was indicated.

“Again, being not that culturally aware, I do not think there are that many religions that involve praying so many times a day. You know? I might be wrong. But her actual need to....She might be out of the room for all of ten minutes and then she would be back in her room again. And if you looked through the window to see what she was doing, then nine times out of ten she would be praying. And in the real world if you like, such as in a community setting, that would have stopped her going to the shop, socialising and working. And that would take over her entire life. So it could be possible that her need to pray was exacerbated by the psychosis. I think that could have been the case that the constant need to pray was exacerbated by the psychosis. So there was a real impact on her ability to function and do the things that we normally take for granted”.

(Male 2nd Year Student, Interview)

“But they clearly did have mental health issues, as their illness was affecting their functioning. I remember going to this person’s flat one day and things were completely chaotic. Things were left everywhere and all over the stairs. Everything seemed to indicate a very chaotic and disordered lifestyle. The purpose of the visit was to pick him up and take him to a rehab place where he could have some respite, because he was getting completely stressed out in his home surroundings. And so when I was waiting for him to pack all of his stuff.....You know? He had this

suitcase, which was falling apart and he was tying the suitcase around with a jumper. He was taking all these crazy things with him, such as bows, arrows, feathers, and things he would not need. And there were things that looked like bits of rubbish tied together”.

(Female 3rd Year Student, Interview)

The registered mental health nurses in Eeles’ (Eeles, 2001; Eeles, Lowe and Wellman, 2003) research also considered that psychopathology was evident where a person was unable to minimally function in basic living and work related activities. In contrast, an ability to function in these activities indicated self-discipline, ordered thought, and grounding in reality-characteristics which were believed to be absent in cases of mental illness. The ‘criterion of function’ (Tseng and McDermott, 1981; Swartz, 1998; Koenig, 2007) is compatible with the ‘absolutist’ and ‘universalist’ (Offer and Sabshin, 1966) models of psychopathology that was outlined in the background review. In the ‘absolutist’/‘universalist’ models, psychopathology “is said to exist when a combination of symptoms occurs, including deteriorating ability to function within social or occupational contexts”, plus “deteriorating ability to care for oneself” (Tobert, 2007, p. 54). Similarly, Sims (1992) writes that psychopathology is evident if the lifestyle, behaviour and direction of the person’s personal goals are consistent with the natural history of mental disorder rather than with a personally enriching life experience.

The assessment of the service user’s behaviour (function) did not just account for its perceived impact on the service user, but also its impact on other people and the service user’s wider community. In the minds of these student nurse participants, behaviour which disturbed or intimidated family, neighbours, and the wider community was considered as ‘dysfunctional’ and suggestive of mental illness. Cultural and societal standards of ‘normality’ came to the fore in these ‘critical incident’ accounts. Note that in the next three narrative extracts; the student nurse participants also drew on the ‘absolutist’/‘universalist’ criterion of ‘insight’ (Carpenter, Strauss and Barktko, 1973) in making their assessments about a service user’s behaviour.

“He had schizophrenia, but he did not believe he had that diagnosis or there was anything wrong with him. He just thought he was fine, although that was clearly not the case. He just wanted to continue the way that he wanted to live without any trouble or anyone getting at him. But he had all kinds of issues because of the way he kept his flat and he had loads of problems with the local council. I believed he was

being summoned to court because of this chaotic behaviour and the effect it was having on his neighbours. So his life was impacting on everyone around him, including his neighbours. So his behaviour was a real problem, as it was starting to impact on the people around him”.

(Female 3rd Year Student, Interview)

“I think that his doctor was rather looking at it from the angle that his expression of his religious beliefs was too extreme now. I think there is a level in society where something is deemed unacceptable and I think it had reached the point where it was not acceptable anymore. I mean, his behaviour could be viewed as being extreme, as he was trying to influence other people and tell them about why they should be Christian. He was like trying to pass his books off; like he would say to people ‘read this’. And he was like saying ‘God be with you’ and things like that. It was overwhelming, but I guess it was down to what the doctor said it was, as being evidence of a psychosis. And he was diagnosed as being psychotic because it was affecting his home life. And he did not have any insight into the level of his behaviour and the problems that it was causing. He was also doing these drastic things in public, such as street preaching. And he did not really get on that well with his family. Again, there was this problem with putting all this stuff on ‘Facebook’ and all these social networking sites. And he was trying to do just that really and just trying to spread the word”.

(Female 3rd Year Student, Interview)

In the next narrative extract, it was not the ideas or beliefs of the service user that are under question or judged as ‘abnormal’. Rather, it was the extremity of the service user’s behaviour and the social context in which it was performed that enabled the student nurse and her colleagues to regard the service user’s behaviour as pathological.

“Another case involved a man from a white British background. He had travelled the world and spent quite a lot of the time in India. I can’t remember the name for his religion, as it was quite an obscure religion, but it involved the use of some kind of ‘water therapy’. Anyway, the practice involves cooling your body temperature down with very cold water and this was the reason why he was admitted on to the ward. He had flooded his house, but he also wanted to practice that water therapy on the inpatient ward. Obviously, his behaviour was quite challenging for the staff, as it was any tap that he was trying to pour water from. He would be in the kitchen on the ward and he would like be in a little area of the lounge where you can make drinks, and he would continue to do it if he had access to water. If he had water, he would take it with him and use it to cool himself down.

It was easier to make the distinction in that case with the patient who practiced the water therapy, because he had actually written books about this practice. So I managed to get a copy of the book from him and it explained quite a lot of the beliefs and they appeared quite normal. Though, it also appeared that the extent to which he was practicing these beliefs was probably not totally normal. So the extent to which he was practicing those beliefs was something to do with his psychosis, but he

would practice those beliefs when he was well anyway. So we were referring to his book which did help us to make that differentiation. It was his book and he had it published. And the book contained information about the timing, what is important to do, and what the beliefs are around water therapy. So by reading that book it really helped....It made us realise that while a belief in water therapy was a legitimate belief, the extent to which he was carrying it out did not seem normal and could be connected to the psychosis.

He also did not believe that he was suffering from psychosis. He had no insight into the fact that his behaviour was now completely socially unacceptable. So that was another factor that we based our assessment on. He believed that you had to practice water therapy naked, but it appeared that his behaviour had escalated from that to walking out in the street naked and practicing this water therapy while being naked in public areas. It is probably acceptable to practice this therapy while being naked in one's home or in private, but he would also practice this water therapy naked in places like ponds and stuff. So clearly that behaviour was not seen as being appropriate or acceptable. As I was saying, it was not the beliefs which was really under question, but rather the extent to which he practiced these beliefs and where he practiced them”.

(Female 2nd Year Student, Interview)

In this instance, it was likely that the service user was employing symbolic systems, but in a manner that would have seemed inconvenient and clumsy to others (Weinstein, 1962). As Lukoff (1985) notes, a person with psychosis will have problems in establishing ‘intersubjective’ reality with other persons in their psychosocial environment. The symptoms of the psychotic illness will impair the person’s ability to relate to others. Thus, dysfunctional behaviour is assumed when a person’s behaviour disrupts or harms the social group in some way. The cultural psychiatrists Tseng and McDermott (1981) refer to the violation of group behavioural norms and the subsequent assessment of ‘abnormal behaviour’ as the ‘criterion of result’. Writing in a similar vein, the medical anthropologist Cecil Helman (2007, p. 246) notes there are:

“A range of possible perceptions, by members of a particular society or culture, of a particular form of social behaviour: whether they see it as ‘normal’ or abnormal for their society, and whether it is controlled, or not, by the norms or rules of that society. It also reflects the fact that all human groups recognise that there are certain times and places when people can be allowed to behave in an ‘abnormal’ way, provided that they are seen to conform to the strict guidelines (explicit or implicit) laid down by their culture for this type of situation. In this case, even if their behaviour is bizarre or unconventional, it is still to some extent controlled by social norms. In contrast, most cultures disapprove of forms of public behaviour that are obviously not being controlled by the rules of their society, and which they usually label as either ‘mad’ or

'bad'. Thus, there are four possible zones of social behaviour according to the perceptions of that society, or of groups or individuals within that society".

In the cases of what Helman termed as 'controlled normality', 'uncontrolled normality', and 'controlled abnormality' however, there is the assumption that whether the person decides to conform to the social norms or not (consciously or not), the person is aware of what the social norms are (i.e., the criterion of 'insight'). That is, the individual has "some degree of self-awareness, or insight, into their own behaviour" (Helman, 2007, p. 246). In contrast, "behaviour is labelled as 'mad' ('uncontrolled abnormality') if it is abnormal, not controlled by social norms, and has no discernible cause or purpose" (Helman, 2007, p. 250). According to Helman, the extremes of the 'uncontrolled abnormality' dimension largely overlap with psychiatric classifications of the major psychoses. The use of these implicit behavioural dimensions in the evaluation of psychopathology was indicated in some of the 'critical incidents' collected for this PhD research. For example, in the student's narrative about the service user who practiced 'water therapy', it could be implied that the behaviour was evaluated as being both 'uncontrolled' (e.g., the naked practice of the water therapy in public spaces violated social norms) and 'abnormal' (e.g., due to the psychosis, the service user did not have 'insight' into the unacceptability of their behaviour).

However, as Helman (2007) explained, these behavioural dimensions are not set in stone, but rather represent "a series of fluid categories, a spectrum of possibilities that are likely to change with time and circumstance and the particular perspective of the onlooker" (p. 246). Thus, there is a temporal and contextual dimension to what is commonly perceived as 'abnormal' (Conrad and Schneider, 1980; Dein, 1997; Benatar, 2006). Behaviour that is viewed as "'bad' in one generation may be seen as 'mad' in the next" (Helman, 2007, p. 246). Furthermore, anthropologists have tended to accept that there is a relative range in which different societies set the boundaries on what can be considered as 'normal' behaviour (Brown, Gregg and Ballard, 1998; Winkelman, 2009).

The evaluation of behaviour with regard to the 'criterion of function' is therefore influenced by cultural norms and expectations (Stolk, 2009). As Seeley (2006) explains, the mental health professions actively instil 'individuated' ideologies of 'self' and cultural expectations of function into clinical practice. Autonomy, independence,

and productivity are values that reflect a 'highly individuated' notion of 'self' (Gaines, 1982b; Gaines and Hahn, 1982), and these values have been shown to underpin clinical practice and the 'criterion of function' (Dyck, 1989; 1991; 1998; Krefling, 1991b; Holden and Littlewood, 1991; Kinebanian and Stomph, 1992; Herberg, 1995; Paul, 1995; Whiteford, 1995; Hocking and Whiteford, 1995; Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; Fitzgerald, et al., 1997a; Gerrish, 2000; Whiteford and Wilcock, 2000; Galanti, 2001; 2005; 2006; 2008; Bonder, Martin and Miracle, 2001; 2002; 2004; Whiteford and Wright St-Clair, 2002; Russell, et al., 2002; Andrews and Boyle, 2003; Fitzgerald, 2004; Bourke-Taylor and Hudson, 2005; Seeley, 2006; Stolk, 2009). Kilshaw, Ndegwa and Curran (2002) note that a mental health worker "who assumes a certain notion of self, of boundaries and of ascribed identity will often fail when confronted with a patient who does not share his or her beliefs" (p. 16). As the following 'critical incident' story illustrates, when the student nurse encouraged a service user to function autonomously, to become more independent from their parents, and to become more assertive, they were inviting them to enact an 'individuated' notion of self (Seeley, 2006), which may not have been compatible with the service user's concept of self and cultural notion of functioning.

"I was on placement in an acute setting and a young lad was admitted. He was in his late teens and was from a Muslim cultural background. He had older sisters who did everything for him. They dressed, fed, and got him up in the morning. This was happening in his home environment. He had no life skills at all and had not developed properly. His brain, social skills, and day to day functioning had not developed sufficiently because everything was just done for him by his relatives. Unfortunately, this lad began to have an episode of psychosis. In the first instance, I did not understand fully that this psychosis had been precipitated by his total dependence on his family members. I think the psychosis may have been a coping strategy. The psychosis was a way of expressing how he wanted to do things for himself. One of the nursing students on placement with me at the time was a Muslim. She said that the breakdown was caused by the older sisters doing everything for him. Everyone was saying to him that 'you need to go out there, get a job, and learn how to be a man'. He did not have a clue about how to be a man. So from my perspective, I wanted to deal with this issue of dependence without being insulting to him or his family. He did make a recovery of sorts and went home. But then you think; have we sent him straight back into the same pampered situation?"

When we did start to teach him life skills and activities of daily living, I think his sisters were happy that we were teaching him these new things. However, at the same time you could see the female members of his family thinking, should we be doing that for him? So it was difficult for them to see that he was looking after himself. He found it difficult and very intimidating performing those activities of daily living when his family was there. It was almost like he was doing something wrong, even though he was

trying to look after himself. The mum was very resistant to the changes that we were implementing and you could not speak to the dad at all. He was not interested in what we had to say...He did not believe any of us. The sisters were the more receptive ones and they were willing to give what we recommended a try. They just wanted to see their brother get better.

He was fine with things like washing and dressing. I think he was fine with performing these activities, because he did not want white female nurses chasing him around the ward. He was saying, 'I will wash myself thank you', and we were saying, 'well could you please get on with it then'. We had to be quite firm with him and he seemed to be okay with us being firm with him. He showed to us that he could get on with it. However, when it came to other activities, he was much more resistant. I remember him being in the games room on the ward with another young lad and they were on the playstation. I watched him and it seemed that he was not willing to get up to fetch the controller that was nearby. I believe that he was not willing to fetch the controller himself, as everything was always handed to him and done for him. I said to him, 'you can get it yourself you know'. Once you gave him that stern kick up the arse he got on with it, but I think he had got away with it for all those years. I don't know whether it was laziness or just that it had always been done for him? Maybe he just expected things to be done for him. I think he needed a break from it all. I think that when he was on the ward, it was really only the time he had experienced some sort of independence in his life. As for eight hours of the day on the ward he was on his own. The guy had never experienced such independence during his life. So he developed the psychosis, as he could not cope all that well".

(Female 3rd Year Student, Interview)

The practitioner needs to ascertain when activities of daily living and self-care are necessary for the service user's recovery and when they are merely an imposition of the practitioner's value system and family structure (Galanti, 2008). Thus, the "cultural meaning and significance of the individual's level of functioning in self-care, autonomy, interpersonal, occupational and other areas of social functioning" (Mezzich, Caracci, Fabrega and Kirmayer, 2009, p. 397) need to be evaluated.

Sims (1992) definition of function (presented at the beginning of this chapter section) relates to another important concept in the health and nursing sciences - that of 'lifestyle'. The issue of 'lifestyle' was implicitly touched on in the previous student nurse's 'critical incident' narrative and also came out in many of the interview narratives that were concerned with the 'criterion of function' in mental health assessments. In some of these cases, the student nurse or their colleagues in clinical placement seemed to have difficulties in separating psychopathology from lifestyle choices.

“My students are all on community placements at the moment. So they are out there visiting people’s homes in the community. What I have noticed and picked up on is how so many of them are really struggling with issues around tidiness and cleanliness and what they perceive as abnormal in that regard. I mean, it maybe somebody’s choice to live an untidy lifestyle. You know? It does not have to be an indicator of poor functioning. It does not have to be a symptom of mental illness. So students have difficulties around differentiating that. You know? Is it a chaotic and unhealthy lifestyle indicating mental illness, or is it just somebody’s personal choice to live like that”?

(Nursing Educator, Interview)

“We had one patient who was sort of in the culture of art and that posed quite a difficult scenario for the mental health team that was working with him, because his lifestyle did not seem very adaptive to us. His perception of art was completely different to the perception of the people that were working with him and seemed to be impacting on his everyday living and the people around him. He felt that getting a bike and putting it in an alleyway which blocked other people’s entrance to the place where he lived was art. So he was being told by art students at a local university that he was very artistic and how amazing these bits of art were. But to us who were working with him on his mental health problems, these bits of art looked just like rubbish. It looked like he was just accumulating rubbish and putting them in different places. So that was difficult to deal with, because what we were saying to him was, ‘you’re cluttering your accommodation and you’ve got a risk of being evicted’. In his eyes, he was part of this art culture.

So that was a tricky one to handle, because it was kind of going against what his culture that he was living in was. And he even said that he can’t understand why because he believes that we don’t understand him. He just thinks he’s been in the (mental health) services for so long that people believe that everything he does is part of his mental illness. So it is a really tricky one really because... It’s as if, as professionals, we’re overlooking...Not overlooking, but not being really sensitive to what our patients are doing. We are maybe classifying them as symptoms of a mental illness, rather than just thinking it may be part of their culture and how they normally live. I think I do that sometimes with the patients”.

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 2)

The issue of ‘lifestyles’, which runs through these two narratives, has been defined in the occupational therapy literature as the degree, range, and balance of self-care, work, and leisure, which are organised into daily, weekly, or otherwise regular routines (Fitzgerald and Mullavey-O’Byrne, 1996). Furthermore, these routines are seen to affect motivation, learning skills, socialisation, and personal opportunities for growth and development. The term ‘occupational lifestyle’ also is frequently used in occupational therapy, and refers to “a person’s total pattern and manner of going about occupations” (Kielhofner, 1995, p. 31). While there is a personal element to

the patterning of lifestyle, these patterns reflect the wider organisation of the social and cultural group to which the individual belongs²⁹ (Fitzgerald, et al., 1997a). These points about lifestyle again demonstrate the need for practitioners to consider carefully the cultural meaning of functioning.

'Multicultural clinical interactions' (Fitzgerald, 1992) not only involve the values of the service user and/or their family, but also the cultural values of the practitioner and their profession (Gardenswartz and Rowe, 1998; Galanti and Sheikh, 2009). Cultural standards of 'normality' and 'function' involve other factors such as appropriate dress, smell, body adornments, communication styles, emotional states, facial expressions, tone of voice, and use of language. The important thing to note is that these factors are all influenced by culture and the 'appropriate' communication of these factors varies by social context and relationship (Pauwels, 1995; Helman, 2007). Social norms also vary by age group, gender, occupation, and social rank, and a host of other social and cultural factors. Some scholars (e.g., Fitzgerald, Mullavey-O'Byrne and Clemson, 1997; Fitzgerald, et al., 1997a; Galanti, 2008; Awaad, 2003; Yang-Shek, Tsunaka and Lim, 2006; Kondo, 2007; Lovering, 2008) have argued that the philosophical and cultural basis of nursing and related health professions needs to be re-evaluated. This re-evaluation especially is needed in clinical interactions and cultural contexts where this philosophical basis is not shared. As Minas (1990, p. 278) explains, in order "to recognise the cultural dimension in patients and their illnesses, clinicians must first become aware of their own cultural encumbrances".

The Assessment of 'Risk'

During the two focus groups with the student nurses, participants repeatedly brought up the assessment of 'risk' as a means of differentiating psychopathological from religious and cultural phenomena. Considering its saliency in the group discussions, it is surprising that the topic of 'risk assessment' was not touched on more explicitly in the interviews. In the focus groups, participants mentioned that the 'risk of harm' was a more important assessment criterion in differentiating psychopathology from religious/culturally sanctioned experiences than the content or falsity of beliefs. In

²⁹Research by Fitzgerald and Mullavey-O'Byrne (1996) found that many students in the health sciences conflate the concepts of lifestyle and culture, and culture was not viewed as something that influences lifestyle.

particular, the participants focused on the perceived 'risk of harm' that the service user posed to themselves and/or to the people around them. A service user who believed that he was an angel with wings that could fly, and who would try to demonstrate this by jumping off tables in an acute assessment ward (posing a health and safety risk and serious self-injury risk), and another service user who would not leave her bed to eat and drink, because she did not want to miss anything that (she believed) the angels were saying to her ('risk of self-neglect'), were examples of religious themed delusions that could pose 'risk to oneself'. The risks of self-harm, suicide and the service user jeopardising their own personal safety were also mentioned and associated with religious type delusions.

Furthermore, in one of the interviews, a student nurse mentioned the perceived risk that a Spanish service user's reported conviction³⁰ in their religious healing abilities posed to other people on an acute assessment ward. The student in this case talked about how the nursing staff prevented the service user from giving herbs to her fellow service users on the ward. It seemed that from the student's version of events, the service user was utterly convinced of the curative or healing properties of these herbs in the treatment of her fellow service users' mental illnesses. However, according to the student, there was a fear among the nursing staff that the ingestion of such herbs would interact negatively with the effects of prescribed medication. Eeles' (Eeles, 2001; Eeles, Lowe and Wellman, 2003) aforementioned research with registered mental health nurses also found that 'risk to self' (by neglect or self-harm) and 'risk to others' (being aggressive, or by acts such as fire setting) were important criteria in the clinical evaluation of spiritual experiences. These issues of 'risk to oneself' and the 'risk to others', which were posed by delusions with religious content are conveyed in the following narrative extracts.

"If there are no consequences to that person's religious experiences.....Negative or...Whatever...Then fine. But I don't think it's fine that you can believe what you like. When it starts to have kind of you know harmful consequences on the patient, then those beliefs are not acceptable. I mean, they go from fasting to their starving themselves, or they think that they're sent or whatever. Or they start to punish themselves and flog themselves, or whatever. I think those lines have then been crossed"

³⁰ 'Conviction' is seen as one of the measurable dimensions of delusions with religious content (Hole, Rush and Beck, 1979; Kendler, Glazer and Morgenstern, 1983; Garety and Hemsley, 1994; Eisen, et al., 1998; Appelbaum, Robbins and Roth, 1999; Pierre, 2001; Dein, 2012).

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 2)

"I think from what I've experienced...I think that as long as what they're saying isn't posing any risk to themselves or anybody else, then I can handle what they're saying. It then does not matter what they believe, as it is not causing them or anybody else any harm. Yes.... I had one guy who thought that God had given him special powers to remove evil forces that might be residing inside other people and that he'd have to get those out of those people. So that posed then a risk to other people.....About how is he going to get things out of people and he discussed what he would do. So I think it can be quite risky at times".

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

These extracts highlight the clinical significance of differentiating delusional beliefs with religious content from normal religious beliefs (Dein, 2004; 2010a; Mahgoub, 2008; Mohr and Pfeifer, 2009). As Kingdon and colleagues' (2010, p. 241) note, although many practitioners "will recall instances of patients with religious delusions who for the most part sit and quietly read the Bible, religious delusions can result in risk to the patient and others". Some of these delusions may focus on literal translations of passages in the Bible and other religious texts, and include themes such as plucking out the 'offending eye'³¹, severing the 'evil arm', 'autocastration', or cutting out the 'sinning' tongue (Blackner and Wong, 1963; Kushner, 1967; Waugh, 1986; Field and Waldfogel, 1995; Thara and Eaton, 1996; Mucci and Dalgarrondo, 2000; Siddle, Haddock, Tarrier and Faragher, 2002; Reeves and Liberto, 2006).

Another piece of research (Patton, 2004) discovered that approximately half of the reported cases of self-inflicted eye injury were associated with psychotic preoccupations about sinfulness and higher deities. Scarnati, Madry and Wise's (1991) research is of significance to student nurses working in forensic placement settings. Their study of psychiatric prisoners in an American penal institution showed that 61% of the inmates believed that God or the Devil communicated directly with them, whereas, some of the prisoners believed that God or the Devil commanded them to do things. Delusions with religious content also have been associated with poorer prognoses and outcomes (Mohr and Pfeifer, 2009). However, the publications just cited have not always clearly defined the proposed mechanism of action for the consequences of having delusions with religious content (Siddle, Haddock, Tarrier and Faragher, 2002). These studies do appear, though, to validate student nurses'

³¹ A person literally following the command in Matthew 5:29 of the Bible: "If your right eye causes you to sin, gauge it out and throw it away. It is better for you to lose one part of your body than for your whole body to be thrown into hell".

reported concerns with risk and being able to adequately distinguish religious themed delusions from normal religious beliefs. Moreover, we must be mindful of the reported tendency by mental health practitioners to pathologise service users' expressions of religion and spirituality (Sims, 1992; 1994; Clarke, 2001). As Fallot (1998) notes, this tendency is fuelled by concerns with legal liability and the 'command' hallucinations experienced by some service users.

Emotional Valence

Some of the participants suggested that negative emotional valence was an important criterion in distinguishing between culturally normal and psychopathological phenomena. For these participants, high levels of distress and negative emotions indicated psychopathology.

"I think that if their (service user's) religious beliefs are not doing them any harm then fine. However, this is not obviously the case if their religious beliefs are doing them harm in some way. What I mean is if they are very negative and distressing, then you have to assess it is mental illness on that basis. As a nurse, you can't ignore that negativity and distress".

(Female 3rd Year Student, Interview)

"The lady that I was just talking about had a diagnosis of schizophrenia and she believed that God was telling her that she was evil. And I think that was quite heart breaking for everyone on the ward, as she was such a lovely woman and clearly was not evil at all. It was really difficult to say to her, 'no, this isn't true', because she may have then perceived you as a liar or that God was lying to her. So you could not say to her that it was not God speaking to you, or that it was a voice in your head that was saying those things. And you could tell it was an abnormal experience, as she was clearly in distress all the time. I believe that from her background and notes, she was a 'Seventh Day Adventist'. It was really heart breaking to see her consumed by the voices in her head and her distress. She would hear these voices all the time and she would just sit down and cry. So that was an abnormal experience to me. I found that really difficult to handle, because while I don't have a problem in principle with people being religious, I just thought how is this helping you? It just seemed to be making her more ill and more miserable all the time. It did not seem to be a coping strategy for this lady. Rather, it was contributing to her problems and exacerbating her condition. But rather than find ways to move forward and forgive herself, she just seemed to blame herself all the time. And she kept on thinking that she was a bad person and how she had made a complete mess of her life. And when she was well, she was just a lot happier and obviously, she did not talk about the voice which had told her how evil she was. She would sit and happily read a Bible and sing hymns. And she would encourage you to sing along with her and what not. So she was talking about her religion, but in a more positive and supportive way".

(Female 3rd Year Student, Interview)

Assessing the clinical significance of religious phenomena by 'emotional outcome' is supported in the research literature (e.g., Slade, 1976; Buckley, 1981; Oxman, et al., 1988; Grof and Grof, 1990; Greyson, 1997; Honig, 1998; Lewis-Fernandez, 1998; Peters, Joseph and Garety, 1999; Peters, Day, McKenna and Orbach, 1999; Pierre, 2001; Butler, 2006; Cardena, Weiner, Van Duijl and Terhune, 2006; Menezes and Moreira-Almeida, 2009; 2010; Peters, 2010; Moreira-Almeida and Cardena, 2011). For one student nurse participant, the positive nature of a service user's religious experience was one of the factors that excluded the possibility of psychopathology. The student distinguished this case from the more distressing and negative experiences with religious content, which she often encountered on acute assessment wards. Again, this interview extract highlights the negative impact on a service user's wellbeing when their experiences are not considered in their context.

"I have found from my own experience on acute placements that even if people are not overtly religious when they are well, when they are poorly religion comes to the forefront far more. This was the case for quite a few of the patients that I encountered whilst working on this acute ward. It was different in the case of this lady, as she was very positive and religion was part of her everyday life. The religious vision she saw just seemed to be a very normal and everyday thing to her. There was no distress in this case. In fact, the most distressing thing for this lady was that the staff did not initially believe her experiences. They had questioned the validity of her experiences by interpreting the religious vision as evidence of psychosis. In fact, it later turned out that she was not suffering from mental illness at all. It was just misinterpretation on the part of the doctors".

(Female 2nd Year Student, Interview)

The criterion of 'emotional outcome' is not a fool proof strategy in the assessment of religious phenomena (Peters, 2010). Indeed, it has been reported that some psychotic patients have regarded their voices as benevolent (Chadwick and Birchwood, 1994) and others have enjoyed their company, and even tried to invoke them (Romme and Escher, 1989). The following narrative also raises the issue of whether 'etic' measurements of function always correspond with a person's subjective fulfilment.

"I have come across a gentleman who's like...His belief in God and belief he was on a path to help God gave him a lot of confidence. He didn't have a lot of confidence before and all of a sudden he had this new found confidence, and he felt able to go out, which he was not able to do before in the past. To him, it didn't matter that no one believed him, as he felt empowered by it and it really empowered him as well. It gave him so much confidence and in the end he learnt to control it and to not talk to people as much about it. Which was sad in a way, as he felt like he couldn't".

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

Peters (2010) suggests that some patients with psychosis have deliberately refused neuroleptic medication, or ingested cannabis (or other drugs) to restore their psychotic states. Presumably, the inducement of a psychotic state is preferable to a non-psychotic reality. Furthermore, although the initial stages of a religious experience can be accompanied by personal suffering that suffering can be overcome as the person comprehends and gains control over the experience (Menezes and Moreira-Almeida, 2009). Thus, using emotional outcome to make a differential diagnosis between a religious experience and a mental disorder with religious content is not without its problems.

Other Strategies

'Relying On Intuition'

A small number of the student nurses reported relying on their own intuitive instincts when trying to differentiate psychopathological from culturally normative phenomena. In the next narrative, the student described this intuitive instinct as a 'gut feeling'.

"It was difficult at first as you are just a student. You are on this ward to learn and observe, but acute wards can be very manic and stressful at times. As a student you can also be a bit unsure of yourself, as you are developing your skills as a nurse in that ward environment. You don't always believe in yourself because you have not got the experience like the registered nurses. However, somebody said to me quite early on in my education that 'gut feelings count for quite a lot'. And when evaluating whether that patient's experience of the 'Guardian Angel' was part of her culture or something connected to a mental illness-I just had the 'gut feeling' that it was a normal experience and part of her culture. 'Gut feelings' seem to be an important element in nursing".

(Female 2nd Year Student, Interview)

The issues (importance) of 'time' and 'being with a patient' are brought out in this focus group narrative.

Male Student 1: *"Again, it's a difficult one of course-unless you know the patient and you know their cultural history and cultural beliefs. I think we do use that as nurses a lot of the time and you do use emotional response sometimes. Sometimes you use that and just get a feeling don't you that something's not right? There is that instinct that something is different and connected to a psychosis. You can then chat with the other nurses on the ward and see if they have that perception as well. If you know their normal behaviour and then suddenly one day they do something that's abnormal and outside that normal behaviour, then it does kick in.... You think that*

there is something different here. But it takes a long time sometimes to get....You have to build up that rapport anyway and you have to build up that therapeutic trust with a patient. You have to take time to do that”.

Male Student 2: *“Especially on the ward if you know what I mean? That ‘instinct’ really is so important. But as my colleague was saying, it can take time to develop with patients. If you know someone well enough it doesn’t matter where they’re from, who they are, religion, or colour of skin, or anything. If you know them or get to know them, then you know their culture. They may be acting normally within the context of their culture, but it may initially seem bizarre to you as a nurse-when you do not know them. But as long as you get the time to know them and you sort of understand them, then when they do something that is even abnormal in the context of their culture, then you can pick up on it quite quickly. So I think it is about how much you know the patient, which you get to know by spending time with them. You get to know how that person behaves in a certain situation. But that kind of ‘instinct’ can take weeks to sort of establish with someone anyway”.*

(Pre-Registered Mental Health Student Focus Group N 2)

The registered mental health nurse participants in Eeles (Eeles, 2001; Eeles, Lowe and Wellman, 2003) aforementioned research drew on their intuitive feelings when assessing the nature of spiritual experiences. These intuitive feelings were reported as being grounded in the therapeutic relationship and in a subjective analysis of the person under assessment. In some cases, the nurse participants suggested that they could detect subtle perturbations in their ability to relate to the service user and with “their interpersonal comfort or discomfort with those under evaluation” (Eeles, Lowe and Wellman, 2003, p. 204). This discomfort was associated with psychotic illness in the person under evaluation. Eeles related this ‘intuitive’ nursing ability to the ‘praecox feeling’ concept (Schwartz and Wiggins, 1987).

The use of ‘intuition’ in the nursing process has been criticised for being ‘unscientific’ and as an ‘irrational’ form of understanding (Ainsworth and Wilson, 1994). On the other hand, it is seen as the hallmark of an ‘expert’ nurse practitioner and an intrinsic feature of the phenomenological approach to nursing (Benner, 1984). Easen and Wilcockson (1996) argue that intuition should be viewed as a non-linear reasoning process, which draws on relevant resources of knowledge and former experiences. From an anthropological perspective however, these intuitive feelings are influenced by the personal/ familial culture of the student nurse and the cultural baggage of the primary medical system (Fitzgerald, 1992; Hahn, 1995). All clinical interactions are ‘multicultural’ (Fitzgerald, 1992).

Religious Coping and Psychopathology

As psychosis is said to involve changes to previous belief systems, some knowledge of the service user's background may usefully inform the assessment process (Kingdon, Siddle, Farooq and Rathod, 2010). However, it can still be difficult for the practitioner to determine exactly when the person started to develop psychotic ideas, especially when gradual change has occurred and the person's beliefs have evolved over time (Kingdon, Siddle, Farooq and Rathod, 2010). Furthermore, an increase in religious activities and/or religious conviction may not necessarily indicate psychopathology, but rather could signify an attempt at coping with the distress of mental illness (ICMR, 1988; Bhugra, et al., 1999; Bhugra, 2002b; King, Weich, Nazroo and Blizard, 2006).

In terms of the empirical findings, a few of the student nurses described how it was often easier to distinguish delusions from normal religious beliefs where the service user appeared to have no religious beliefs prior to the onset of psychosis. Conversely, it seemed more difficult to separate psychopathology from normal religious beliefs when the service user had a religious background before the development of psychosis.

"I've had some service users who are very religious and I haven't known them before they might become ill. So I don't know whether that's part of their illness or not, but if it supports them you can be supportive of that. On the other hand, if you know they have no religious background from their psychiatric history and they start expressing loads of religious ideas-then you can take that as a sign of their illness".

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 2)

In the next narrative, the student nurse interprets a sudden religious conversion during a psychotic episode as evidence of psychopathology. This brought to mind William James' (1961) observation that sudden religious conversion is more likely to occur in the 'sick soul' than in the 'healthy minded'.

"There was another patient on this ward and she had never shared with the nursing staffs before any Muslim beliefs. Then she suddenly decided that she was a Muslim. She was convinced that she was a Muslim and she had been for her entire life. This was with a lady from a white ethnic background who had expressed no religion before this. There was nothing in her notes about this. She was sectioned, but she was allowed out on escorted leave. And she then just came back in on the ward one day and she was dressed fully in the Muslim attire. She was like; 'I am a Muslim and I have always been'. But that was probably more to do with her illness. She sort of

showed the same.....As this other lady. Was she copying this other lady and her religious practices? So it was hard to say. I think it was one of the healthcare assistants that said to her; 'do you realise that you cannot drink and smoke when you are a Muslim'? And she was like; 'well I can. I can in mine'. So in that sense, it was probably something to do more with her illness that was causing her to act like that. She was somebody where their illness did make them act differently and she had so many different personalities and things. So it was definitely easier with that patient than the Afro-Caribbean lady that I mentioned. With the other Afro-Caribbean lady, there was no way for us nursing staffs to say; 'well, it is a product of her illness'. There was no way that we could say that because nobody knew and nobody had come into contact with her before. We did not know her full background and about her religion-so we could not make that determination".

(Female 3rd Year Student, Interview)

One of the concerns expressed by practitioners in Kilshaw, Ndegaw and Curran's (2002) qualitative study of mental health professionals' clinical interactions with Afro-Caribbean service users, was if a service user had suddenly become religious or more religious recently. Such changes in religious conviction were seen by the professionals as pointing to psychopathology. Thus, religion was, in many cases, regarded as pathological, problematic, and harmful. As Loewenthal (1999; 2007) notes, there is much evidence in the clinical literature to suggest that the past tendency to misdiagnose religious coping behaviour as symptomatic of psychopathology still endures in clinical practice.

Although such changes in religious conviction and/or activity might be evidence of increasing distress, only viewing it in this light is problematic (Kilshaw, Ndegwa and Curran, 2002). A few of the student nurse participants mentioned that the service user under their care and supervision was possibly drawing on religious practices to cope with the distress of psychosis. The implication, therefore, was that the practices were not necessarily psychopathological.

"On the acute assessment ward there was a lady who came in and she was....When they brought her in and assessed her, she had surrounded herself with crosses. She had just got Christianity crosses everywhere and I believe that it was a new religion for her. But that was seen as part of her psychosis. She was like really... She was turning to God and stuff. But she's just gone through a divorce. She just like split up from her husband. She has got no family over here...So it might be just that she was very distressed at that time".

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

Koenig (2007) notes in his review of the religion and psychotic disorders literature that much attention has focused on the role that religious conversion plays in the aetiology of psychoses. Several studies (e.g., ICMR, 1988; Bhugra, et al., 1999; Bhugra, 2002b) have found that changes in religious activity or interest follow rather than precede the onset of psychotic illness. In particular, research, which has been conducted in India, revealed that 22% to 27% of patients with a diagnosis of schizophrenia reported an increase in religious activity following their diagnosis (ICMR, 1988; Bhugra, et al., 1999). These findings showed an increased resort to religious beliefs and practices in order to cope with the distressing nature of psychotic illness among a highly religious population. In a UK based study, Dinesh Bhugra (2002b) examined service users from four ethnic groups (e.g., Trinidadian/London, White/London, Asian/London, African-Caribbean) with signs of first-onset schizophrenia. It became evident that religious conversion was secondary to the development of the psychosis. Furthermore, many of the service users had converted to a new religion following their diagnosis. Bhugra wrote that such conversions were at least some attempt at regaining self-control as the self-concept began to alter with the emergence of psychotic symptoms. One explanation based on Bhugra's findings, is that when a person is experiencing distress, they may adopt religious coping behaviours which decrease when there are signs of remission. An increase in religious conviction and/or activities, therefore, is not so much symptomatic of psychopathology as a form of coping with distress (Loewenthal, 2007).

Kilshaw, Ndegaw and Curran (2002, p. 98) also observed that it "is not uncommon for people to use familiar, yet previously unaccessed belief systems to explain and cast meaning on their experiences". Therefore, "premature judgements rooted in a theoretical connection between religion and psychopathology fails to do justice to the multiple and diverse functions that religious and spiritual experience may play in the lives of consumers" (Kilshaw, Ndegwa and Curran, 2002, p. 100). Fallot, Freeman and Hayden (1997) suggest that the practitioner can avoid making such premature judgements by making a careful assessment of the role of religious beliefs and practices in the service user's overall life structure and functioning. This is especially important when research has shown that religion can be a coping mechanism that

reduces anxiety and assists in recovery from mental illness (Park, Cohen and Herb, 1990; Fallot, 1998) and other disorders (Matthews, et al., 1998).

Summary

When attempting to differentiate psychopathology from culturally validated phenomenology, student nurses and their colleagues in clinical placement assessed 'functioning', 'risk', and 'emotional valence'. These assessment strategies are associated with the criterion of 'outcomes' (Jackson and Fulford, 1997). The criterion of 'outcomes' suggests that negative as opposed to neutral or positive outcomes are suggestive of psychopathology. In some cases, the participants made a connection between loss of function and a lack of 'insight'. Some of the participants also described how they often relied on their 'intuition' or 'gut instincts', while others evaluated the experience from the perspective of the service user's religious background.

These criteria need to be considered carefully within the service user's local context. This point seemed to have particular saliency for the assessment of function. Thus, a nuanced understanding of the "sociocultural context in which the service user lives is vital, not only in accurately assessing psychopathology but in evaluating skills, personal and social resources, and coping capacities" (Minas, 1990, p. 278). At the same time, culturally appropriate and therapeutic care can only occur if the practitioner carefully considers the influence of their personal/familial culture and the cultural baggage of the primary medical system (Fitzgerald, 1992). The next chapter further explores how the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) was addressed in student nurses' clinical placements. In particular, the focus is on approaches which saw phenomenology as not being consistent with local context (Wing, Cooper and Sartorius, 1974).

Chapter 8

‘Dealing’ with the ‘Normative Uncertainty’ Evaluation Dilemma: The ‘Importance’ of Context

Introduction

I describe in this chapter how mental health student nurses and their colleagues in clinical placement drew on their own stocks of cultural knowledge, or sought the advice of culturally informed staff members, the service user’s family members, or religious group spokespersons when differentiating psychopathology from culturally normative phenomena. These approaches attempted to evaluate psychopathology in its local (‘cultural’) context (Wing, Cooper and Sartorius, 1974). In this chapter, these approaches are situated within the medical anthropological literature on ‘cultural brokerage’ (Willigen, 2002; Lo, 2010), ‘explanatory models’ (Kleinman, Eisenberg and Good, 1978), and ‘clinical recognition’ (Carpenter-Song, 2011).

Cultural Knowledge

There were a few ‘critical incidents’ where a mental health student nurse or professional colleague drew upon their own personal store of cultural knowledge in order to differentiate psychopathology from culturally normal phenomena. A student nurse participant even mentioned using information she had obtained from mass media sources to differentiate psychotic influenced delusions from normal religious beliefs. The reliability of such information was not questioned in this instance. Other student nurse participants suggested that they applied their own religious beliefs when differentiating delusions from normal religious beliefs. The assessment criterion in these cases was based on the content of the beliefs and their (in)compatibility with what was perceived as religious orthodoxy. Two of these students saw the service user when they were well or in recovery and when they were experiencing a psychotic episode. Their assessment was therefore also based on the psychiatric history of the service user. According to these two student nurses, the psychotic episode had drastically altered the manifestation and content of the service user’s beliefs.

“Yes, definitely....I draw on my own religious beliefs. And because of my beliefs, I can usually tell that someone is psychotic, as their normal religious beliefs do not usually go along with their illness. The psychosis seems to drastically change and

alter the expression of their religious beliefs to when they were well or in recovery. When they are psychotic, the expression of their religious beliefs does not go along with the conventional wisdom of a religious worldview. Even if you have got some background knowledge about the religion you can never get it right in their eyes”.

(Female 3rd Year Student, Interview)

“The lady I am thinking about now was in her fifties and I had some knowledge of her religious beliefs because of my Irish and Catholic background. And I saw her when she was well as well. So she was very different when she was unwell and when she was in the manic phase of her bipolar illness. She had it in her head that she was going to marry God and she needed to divorce her husband. Which was obviously weird as it conflicted with her very strong Catholic beliefs? And anybody that disagreed with her, she got extremely angry with”.

(Female 2nd Year Student, Interview)

In the next narrative, a student nurse participant talked more specifically about how he drew on his Christian religious beliefs when differentiating psychotic delusions from normal religious beliefs.

“There was this patient whose experience of God I found very hard to balance with my own beliefs. He was from a Christian evangelical background. I think he attended an Afro-Caribbean church. He had developed psychosis as a consequence of smoking too much cannabis. I think his parents were very much involved with the church. I think that his dad was a pastor at one of the churches. So his psychosis was induced by cannabis. But his beliefs seemed to fixate around reading the Bible and praying constantly, as he believed that would keep evil people and the Devil at bay. However, his ideas about the Devil didn’t seem to match up with Biblical tradition. His beliefs matched up more with a kind of mystical tradition. It was the kind of thing you would see in the ‘Simpsons’ cartoon.

I come from a Christian background, so I am aware of praying and actively listening to the voice of God. However, when someone says ‘Jesus has told me to do this’ and it is directly in conflict with something in the Bible-for me personally that is a difficult boundary to deal with. However, as a nurse, I have got to define whether that is psychosis. If so, should I treat that or should I go with the recovery model, accept this behaviour and get them to act in a way that will be beneficial for them. So it was much easier to ascertain that the Afro-Caribbean gentleman was suffering from psychosis. In the case of the Afro-Caribbean gentleman, I could draw on my own personal Christian beliefs to see whether this chap’s beliefs accorded with accepted Christian tradition. Like I said, I could work out that his beliefs about the Devil did not accord with Christian tradition”.

(Male 2nd Year Student, Interview)

This narrative and other critical incidents like it brought to mind the concept of 'clinical recognition'³² and how it should "be configured" (Carpenter-Song, 2011, p.79) in 'multicultural clinical interactions' (Fitzgerald, 1992). To put it another way, problems arise when the practitioner's cultural knowledge or understanding of a clinical issue is used reductively—that is, in a way that bounds the experience of the service user by not asking the service user "who are you?", but to claim "I know who you are" (Carpenter-Song, 2011, p. 179)! This critique bears resemblance to the anthropological critiques (Culley, 1996; 2000; 2001; 2006; Santiago-Irizarry, 1996; Good and Hannah, 2010; Willen, Bullon and Good, 2010; Good, Hannah and Willen, 2011; Kirmayer, 2012) of culture specific (competence) knowledge that were discussed in the first findings chapter. Or as one nursing educator noted when talking

³²Carpenter-Song (2011) in her theory of 'recognition' in clinical relationships builds on Judith Butler's (2005) work on the conception of the self and recognition. In particular, Carpenter-Song notes (2011, p. 176) that "Butler writes against a certain formulation of the self as individualistic as well as transparent and, thus knowable", thus positing "the fundamental relationality and opacity of the self". Such a conception of the 'self' as opaque and constituted through relationships holds "a specific implication for an ethical bearing towards the other" (Butler, 2005, p. 20) in the clinical relationship. Drawing on the work of the feminist philosopher Adriana Cavarero, Butler (2005, p.31) states that "the question most central to recognition is a direct one and it is addressed to the other: 'Who are you?'". According to Butler (2005), this 'who are you' "question assumes that there is an other before us whom we do not know and cannot fully apprehend" (p. 31). Carpenter-Song (2011, p. 176) argues, that this "resounding question—who are you?—is a crucial one for therapeutics" and particularly "for mental health care because the self is fully implicated in mental, behavioural, and emotional problems (compare Estroff, et al., 1991)". The conditions and dynamics of clinical recognition "consist in the time taken in the encounter, in remembering details of context, in continuity, in listening and bearing silences, and in the ineffable—what one feels 'chest to chest, breast to breast'" (Carpenter-Song, 2011, p. 176). There is a need to remain constantly open and curious "and not predetermine what's going to come out" of the service user's mouth (Carpenter-Song, 2011, p. 177).

By bringing recognition to the fore of the clinical process, Carpenter-Song suggests that the practitioner can elide what Foucault (1973) described in 'The Birth of the Clinic' as the fundamental shift in biomedicine from 'how do you feel' to an explicit focus on 'where does it hurt'? The qualities of uncertainty and opacity therefore become the fundamental conditions of, rather than obstacles to the clinical process (Carpenter-Song, 2011). When the practitioner continues to ask the service user 'who are you', the practitioner is "introduced to greater and greater specificity and singularity" (Carpenter-Song, 2011, p. 177), a point articulated by Paul Verhaeghe (2004) in his distinction between medical and clinical psychodiagnostics. This point was also echoed by John Strauss (1994, p. 106) who wrote that "life is in the details" and there is nothing general about life. Furthermore, recognition is never complete, "but instead exists on an ever elusive horizon" (Carpenter-Song, 2011, p. 178). For a practitioner to recognise that they do not know everything brings to mind Butler's (2005) argument that recognition constitutes "a disposition of humility and generosity alike" (p. 42)—a perspective echoed by the 'cultural humility' approach to cultural competence (Tervalon and Murray-Garcia, 1998).

According to Carpenter-Song (2011), the ethical stance of desiring "recognition without any expectation of a full or final answer, may be important for all patients, and may point the way toward a more informed universalism" (p. 178). However, this imperative is likely to become more apparent in clinical contexts of 'hyper diversity' (Hannah, 2011), where service users have different expectations of care, help seeking behaviours, and limited English language proficiency (Betancourt, Green, Carrillo and Park, 2005). At the same time, one cannot deny the structural constraints of the political economy of care or the cultural ideology of the primary medical system on the dynamics of clinical recognition (Lo, 2010). Carpenter-Song (2011, p. 180) notes that practitioners "can only be good as the conditions in which they practice".

about how mental health student nurses apply their own religious beliefs in differentiating delusions from normal religious beliefs:

“But I do wonder if that alternatively means that there was only one interpretation for those patients as well. Does that make sense? So it is kind of the right thing to do, but it is also worrying...That might limit things too much the other way and there then isn't a balance”.

(Nursing Educator, Staff Focus Group)

In contrast, 'clinical recognition' "implies a stance, an inclination toward the other that desires to know but understands the utter impossibility of realizing that longing" (Carpenter-Song, 2011, p. 179). The concept of clinical recognition therefore, is grounded in the experiences of service users and practitioners and approaches difference ('otherness') through openness (Carpenter-Song, 2011).

In the next critical incident, the student nurse participant described in detail how they were able to provide significant input to a primary health assessment. The student was able to do so by drawing on their own cultural knowledge of a form of self harm that the nurse in charge of the assessment was not culturally aware of. Thus, the clinical evaluation error: Diagnosing the signs and symptoms of psychopathology as cultural differences (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Dein and Lipsedge, 1998; Stolk, 2009) was avoided in this clinical interaction. The other important point to note is that the student did not just draw on this cultural knowledge to make an assumption ('I know who you are' [Carpenter-Song, 2011]) about the service user's behaviour. In fact, according to the student's account of events, this cultural knowledge was used as a 'guide post' (Galanti, 2008) to explore the meaning and context of the behaviour with the service user ('who are you?')[Carpenter-Song, 2011]).

“I was recently on a primary health assessment where we had a young guy come in....Who came in and he was describing interactions with his friends that the nurse undertaking the assessment had no knowledge of. He was talking about self-harm and he was saying that he and his friends do these 'smileys'. It just made me realise the barriers and the cultural differences, because I knew what he was talking about, even though the nurse doing the assessment didn't. And I could then explore with him, about whether he was doing this on his own or with his friends. The nurse in charge of the assessment was a lot older than me. I think she was in her early sixties and she had no idea about what a 'smiley' was. A 'smiley' is where you light up a lighter and then burn yourself. It then leaves a scar that looks like a smile. So the nurse in charge was thinking that it was just about him having a laugh with his

mates. However, for me knowing what a 'smiley' was....I was able to say to him, 'well do you do it on your own or do you do that with other people'? He said 'no, I do it on my own most of the time'. It is normally carried out in a situation where a group of friends is goading each other on. I have known people to do it, because of peer pressure and trying to show off and stuff like that. Of which he said he did do, but he also went on to say he did it on his own, which is in a completely different context.

I had not heard of people doing 'smileys' on their own before. I went away thinking that obviously, that must be abnormal behaviour. I felt that in this situation, I was able to contribute a lot more information to the assessment. I was able to inform the nurse who had no knowledge of what a 'smiley' was and what it involved and stuff like that. So I felt I could contribute and actually say it was self-harm. I mean, the nurse initially just thought, it was him just larking around with his mates and she had no idea of what it was. He just kept saying 'smileys' and that was really the only information that he was giving. And she was sitting there thinking; well what is that? I then asked him, 'what situations do you do it in? Is it on your own or is it with a group of people and how often do you do it'? And I was just trying to get as much information about it as possible. Rather, than just dismissing it as an act of larking around with his mates. He also had ADHD and he had very high anxiety. He was learning about how to manage that and involved in that was the self-harm. He said that he burnt himself with a lighter as it was a release and it made him feel that he was in a bit more control of things. It could have been easy to say 'oh, it is just him larking around with his friends'. But the reality of the situation was that he was also doing it on his own and for different reasons rather than just people goading him on".

(Female 2nd Year Student, Interview)

This student's narrative shows that even the assessment of risk is not always a cut and dried issue and may need to account for cultural norms (in this case, the subcultural norms regulating the practice of 'smileys') and the context in which the behaviour was enacted. Once again, we can see the possible relevancy of Helman's (2007) 'dimensions of social behaviour' model in understanding how the student nurse participant came to define the service user's behaviour as a form of self-harm ('uncontrolled abnormality'), rather than as a culturally normal behaviour (i.e., a 'smiley' is a culturally acceptable form of behaviour when carried out in a group context with friends ['controlled abnormality'³³])-albeit in its subcultural context.

³³ Helman (2007, p.247) defined 'controlled abnormality' in the following quotation.

"Most societies, especially those with rigid codes of normal behaviour, often make provision for certain specified occasions where these codes are deliberately flouted or inverted, and 'abnormal' behaviour whether of the individual, or of the group, becomes the temporary norm. Despite this, their behaviour is actually tightly controlled in terms of where it happens, and for how long it lasts, although to the outsider it may appear wholly abnormal. One example of this, has been called by anthropologists 'rites of reversal' or 'symbolic inversions', which Babcock defines as 'any act of expressive behaviour that inverts, contradicts, abrogates or in some fashion presents an alternative to

Cultural Brokers

Some of the participants felt that it was important that the service user's experience was understandable to someone who was perceived to share the cultural background of the service user. This someone could be a family member, culturally informed staff member, or religious group spokesperson. These are just a few of the 'cultural informants' or 'consultants' mentioned in the academic literature (Davis, 1994; 2000). They also bring to mind the more formal role associated with that of the 'cultural broker' (Weidman, 1982; 1983). The idea of cultural brokerage was originally developed by the cultural anthropologists Eric Wolf (1956) and Clifford Geertz (1960), and has generally been seen as a way of bridging, mediating, or linking persons or groups from different cultures (Lo, 2010). In the clinical setting, the notion of cultural brokerage has been applied to studying the roles of nurses (e.g., the nurse as broker between the service user and the primary medical system), cultural interpreters³⁴, medical interpreters, and group spokespersons³⁵ (Tripp-Reimer and Brink, 1985; Barbee, 1987; Jezewski, 1990; Bonder, Martin and Miracle, 2002; Hsieh, 2006; Fontes, 2008). A cultural broker helps to decrease the disparity between the cultures present in a clinical interaction by providing the participants (i.e., practitioners and service users) with information about one another's cultures and medical systems (Fitzgerald, 1992). The following definitions help to convey the essence of cultural brokerage in the clinical context:

"An intervention strategy of research, training, and service that links persons of two or more socio-cultural systems through an individual, with the primary goals of

commonly held cultural codes, values and norms be they linguistic, literary or artistic, religious, or social and political'. Often they are ways of 'letting off steam', of allowing people to express themselves, and feel free of social constraints, but only under controlled conditions".

³⁴ There are a number of people (e.g., medical anthropologists) and organisations that can act as 'cultural interpreters' (Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997). The role of these people and organisations is to provide access to relevant cultural knowledge that may inform clinical practice. This knowledge may be culture specific or more general. An example of the type of person that performs this role is someone who is a member of the same group as the service user, but who is somewhat familiar with the procedures, systems and values of the primary medical system (Bonder, Martin and Miracle, 2002). The 'Transcultural Mental Health Centre' in Australia and the UCL (CCS) 'Cultural Consultation Service' are examples of such organisations. The UCL 'Cultural Consultation Service' provides 'cultural formulations' for service users and health professionals in the NHS and private healthcare sector.

³⁵ This can be a person or organisation who claims the role of spokesperson for a group of which the service user is assumed to be a member (Bonder, Martin and Miracle, 2002). Tribal elders, religious authorities, and public figures representing a recognised organisation are examples of group spokespersons, and can all emerge as brokers in clinical interactions.

making community service programs more open and responsive to the needs of the community and of improving the community's access to resources".

(Willigen, 2002, p. 131)

"A cultural broker is a person who serves go between functions at the edges of cultural groups in contact. They often interpret the behaviour of members of each group to the other. Because they are usually native to one group but have some sort of language skill with the other, even if it is only a partial knowledge or trading language, they have specialized expertise that is not shared with other members of either group. Such individuals are invaluable in situations of culture contact".

(Bonder, Martin and Miracle, 2002, p. 117)

Cultural brokerage draws on the perspectives of 'cultural relativism' (Ben-Tovim, 1987; Fitzgerald, 1992), particularly the necessity for the practitioner to understand something about the culture in which a person is embedded before deciding whether apparent symptoms are pathognomic and evidence of an underlying psychiatric disorder (Bhugra and Bhui, 1997). For example, the content of a person's delusions is derived from their cultural orientation and is therefore liable to be recognised as such, if the practitioner consults with people who share a similar cultural outlook to the service user (Lyles and Hillard, 1982; Gaines, 1988; 1995; Rack, 1990; Levy, 1996; Paniagua, 2005). Seth Donal Hannah (2011, p. 40) notes that this "reflects the theory of explanatory models that underlies how cultural issues are often understood in the contemporary culture of medicine". However, Hannah (2011, p. 40) suggests that "by seeking the advice of cultural brokers or others who share the cultural identity of the patient", the practitioner does so "in a way that uses identity as a proxy for culture". As Hannah (2011, p. 40) explains:

"The use of identity as a proxy for culture makes sense when the link between the two is strong. But what happens when the link breaks down? If clinicians and support staff are operating on the assumption that racial or ethnic membership is coherent and persistent and that members of these groups share a bundle of relevant cultural characteristics, they may treat patients differently on the basis of that assumption. This works fine as long as the cultural assumption is accurate. When it is not, inappropriate stereotyping, misdiagnosis, and mistrust can occur".

Hannah notes that a classic example is the tendency of psychiatrists to over diagnose black males with schizophrenia (Good, James, Good and Becker, 2002). In particular, research (Metzl, 2010) has indicated that this over diagnosis is based on psychiatric assumptions about the cultural characteristics of black males (e.g., the assumption that black males are prone to violence).

Consulting with Family

The anthropologist sees social relationships such as familial ties as integral to the understanding of an individual (Kilshaw, Ndegwa and Curran, 2002). Moreover, anthropological perspectives stress that the self is not bounded, but develops and changes as a result of several factors (Kilshaw, Ndegwa and Curran, 2002; Seeley, 2006). Gaines (1995) has argued that family members may be experts in the logic of their own culture and therefore, “can serve as guides to the assessment of acceptable and unacceptable ideation and behaviours based thereupon” (p.283). Similar arguments were made by some of the student nurse participants.

“But I think it’s difficult to differentiate between their psychosis and culture and what they believe in, unless you know their history and their family background and what they do in terms of their religion. You need to consult with that person’s family members as it’s difficult to know whether they are having delusional beliefs or hallucinations, or if it is a cultural belief. You need that cultural context really and the family is an important part of that context”.

(Male 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 2)

Two of the critical incident stories specifically were about how the family became involved in the assessment of a service user’s expression of religious belief. These participants spoke about the value of exploring religious norms with the service user’s family. One of these participants talked about the importance of involving the service user’s family network in a multidisciplinary team meeting, in which the ‘normative uncertainty’ evaluation dilemma (Good and Good, 1986) was a significant issue. In this case, the mental health team tried to resolve the issue by evaluating the service user’s beliefs within the context of the family’s religious life. When placed in the context of the family’s cultural frame of reference, the service user’s beliefs were seen as delusional and therefore associated with a psychotic illness.

“We got the family involved with the ‘MDT’ (multidisciplinary team) meetings. Where with the patient’s family, we were trying to work out what was going on in this case and find out more information about the patient’s and family’s religious background. By finding out more about the family’s religious background, we were hoping that we could find out whether this patient’s religious beliefs were genuine or were associated with the psychosis. So we held lengthy discussions about that with the family members. It appeared from what the family members were saying to us at the ‘MDT’ meetings that his beliefs were not a genuine expression of the family’s religious beliefs. We were able to conclude from those ‘MDT’ discussions with his family members that these beliefs were more likely to be connected to the psychosis. Towards the end of his treatment on that acute unit, I think his brother cleared up a

few things, because he (service user) used to say things about this person who did not seem to be real to us. I think it was like his imaginary friend and when he was younger, he used to call out this name. So his brother cleared a lot of things up, as this name kept on coming up....Because his family didn't really....His mum and dad did not realise who this imaginary person was. But he kept talking about his god and this imaginary friend. But it was still hard to make that call and I think it would have been much harder if his family was not there to clear things up. But as I was saying, it was quite useful to consult with the patient's brother, and it did appear that what most of what he was saying did not relate to the family's religious beliefs".

(Female 3rd Year Student, Interview)

The actions of the student nurse participant and her professional colleagues in this instance was congruent with the advice set down in the DSM-IV (American Psychiatric Association, 1994, p. 765), that "the belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith)". With the input of the service user's family, the 'culture as a red herring' clinical assessment error (Stein, 1985)-that is, assessing the signs and symptoms of mental illness as cultural differences—was avoided in this situation (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Dein and Lipsedge, 1998; Stolk, 2009). The value of consulting with the service user's family about the issue of 'normative uncertainty' is supported in the limited amount of empirical research on the topic. Fitzgerald and colleagues' (1997a) qualitative study found that it was only after working with the service user's family that some of the mental health occupational therapist research participants began to realise how important cultural issues were to particular cases. This point is reflected in the following quotation from an interview with an occupational therapist.

"It was only after the family was involved that I could see how different their values and beliefs were, that I could see that culture was playing an important part. It probably would have been different if the family had not been involved. I would not have realised how important the role of culture was. Because he was confused and had difficulty expressing himself, I did not realise what a big barrier that (culture) was as well".

(Fitzgerald, et al., 1997a, p. 66)

Similar findings emerged from Eeles' (Eeles, 2001; Eeles, Lowe and Wellman, 2003) research into the criteria that a purposive sample of UK registered mental health nurses used to evaluate the clinical significance of spiritual experiences. In particular, Eeles found that it was more important that the experience was understandable to those people close to the service user (e.g., family members) than

it was to be sanctioned by the mental health nurse. As Eeles, Lowe and Wellman (2003) note, many of their nurse participants “were keen to discover how those close to the subject understood what was happening to them; did they think it normal, were they concerned about the individual’s behaviour”? (p. 202).

However, the practitioner also needs to be mindful of any conflict between the family and the religious organisation that the service user is involved with (Kingdon and Finn, 2006). Indeed, the family may view the service user’s involvement with the religious organisation as undesirable or even as an aspect of the service user’s psychopathology (Kingdon, Siddle, Farooq and Rathod, 2010). Furthermore, there can be personal antipathies between family members that place into question the value of consulting with family members; not to mention valid concerns about protecting the privacy of the service user (Rack, 1982; Kirmayer, Young and Hayton, 1997). The latter issue with specific reference to service users from non-English speaking backgrounds was raised in the focus group sessions.

Male, Student 1: *“One of the things I find is that while we always gain consent from the patient to use their relative as an interpreter, when it is a general communication issue, when it is about cultural aspects and that differentiation issue of separating culture from illness, it seems we forget to ask the patient for their consent. It is like; ‘well they won’t understand anyway’. So we go straight to the family. So how do we know that is what the client wants”?*

Female, Student: *“And dignity as well; are you respecting that there’s certain things that the patient might not want you to disclose to their family”.*

Male, Student 2: *“And they might not want you to disclose to their family and that’s why I think it’s best to ask the advice of another colleague from a similar background to the service user or an interpreter. Though, it is obviously difficult, because you then don’t get the family involvement. But there’s always....It is never clear; ‘well have they given consent’? Have they signed a consent form”?*

(Pre-Registered Mental Health Student Focus Group N 1)

Similar issues are mentioned in the literature dealing with the ethical problems of family members being asked by health professionals to perform the role of interpreter (Pauwels, 1995; Sobo and Seid, 2003; Fontes, 2005; Culley and Dyson, 2010). An excellent review of these ethical issues is given in Lisa Aronson Fontes’ (2008) book *Interviewing Clients across Cultures: A Practitioner’s Guide*³⁶. To

³⁶For example, Fontes (2008, p. 149) explains that there may be “problems of *perceived* lack of confidentiality” by asking family members to act as interpreters. Fontes (2008, p. 149) suggests that even “if the person (family member) interpreting does not actually betray confidences”, the service

prevent such problems from occurring, Kingdon and colleagues' (2010) recommend that mental health trusts make provision for independent cultural consultancy (brokerage) services.

The value of consulting with family members about the problems presented by the 'normative uncertainty' evaluation dilemma is further questioned in the following 'critical incident' narrative. In this narrative, the concern arose from a different source; namely, that family members' 'explanatory models' (Kleinman, Eisenberg and Good, 1978) may not always be congruent in their understanding of the service user's experiences. This narrative brought to mind the question of whether the family member will need to have some understanding of the biomedical model of mental illness in order to inform decision making around the 'normative uncertainty' evaluation dilemma.

"There was a service user on the rehab unit who was an Asian male. He was schizophrenic and he used to hear voices. And his brother was quite insistent that he took his medication and stayed on the rehab unit. He used to go home at the weekends from Friday to Sunday. His parents and his brothers would come and pick him up from the rehab unit. On one occasion however, his brother had gone back to India for one month and was quite anxious about him going home, as his mother was quite happy about him hearing voices. She thought it was normal and that he was chosen and special, as he could hear these voices. From the perspective of her cultural background, it was quite normal for people to hear voices, but the brother was like; 'no, he is ill'. You know? These voices are not anything to do with culture but a part of his psychosis. You could not like consult with the mother or the father about their son's voices. They just had no concept of mental illness at all. Anyway, his brother was accepting that he had schizophrenia and it was like; 'well, he does need the medication'. And according to the brother, the medication did work as it controls some of these hallucinations that the patient was experiencing. So his brother's explanation was that he was ill. But how much the patient's mother knew about mental illness, I do not know really. So that was it really. I would say that was more about his family really and his mother's interpretation of his illness, which conflicted with that of his brother's".

(Female 3rd Year Student, Interview)

The next narrative raised similar issues, but in this case the student nurse participant reported that fellow staff members were a more reliable source of information about the problems presented by the 'normative uncertainty' evaluation dilemma than the service user's family members.

user may "worry about this". Fontes' recommends that family members should not be asked to take on the role of interpreter, except in cases where the service user explicitly requests their family member to do so.

“I think it’s easier to ask other staff or people that don’t have anything to do with the person (service user) themselves. We have got a woman on the ward at the moment and she knows she is unwell. But her mother is like ‘oh, it’s just the devils’. She just believes that her daughter is possessed by devils at the moment. So it is easier to go to someone else and say ‘is that normal for that religion’? Rather than a family member....That is my experience of that type of situation”.

(Female 2nd Year Student, Pre-Registered Mental Health Student Focus Group N 1)

Bicultural and Culturally Informed Staff Members

The mental health practitioner may seek the advice of a culturally informed or bicultural colleague. Paniagua (2000; 2001; 2005) suggests that such collaboration can reduce the risk of idiosyncratic decision making. It is implied that bicultural or culturally informed health professionals may be able to bridge the ‘disease’ (‘etic’) perspective of biomedicine and the ‘illness’ (‘emic’) perspective (Eisenberg, 1977; Skultans and Cox, 2000) of the service user, and therefore, encourage practitioner and service user to confidently engage with each other (Robinson, 2002; Mir and Din, 2003; Mir, 2007). The previous ‘critical incident’ narrative suggested that it was preferable to seek advice from culturally informed staff colleagues than family members about the ‘normative uncertainty’ evaluation dilemma. There also were other critical incidents that appeared to reinforce the argument about the benefits of collaborative decision making with culturally informed or bicultural staff colleagues.

“This situation took place on an acute mental health ward. The woman (service user) in question had special dietary requirements and would also talk about spiritual things. She would talk about ‘Mohammed’ as she was from a Muslim background. I do not know anything about Islam or about Pakistani culture. But the Pakistani nurse who I was working with on that ward really worked well with this lady. This nurse was a very informative source for all the staff members, as she had an understanding of the spiritual things that this woman was talking about. So she worked really well with her and often she (Pakistani nurse) would say to the team, ‘oh, when she says this she means this. Please don’t worry when she mentions Mohammed and she is on about this type of thing. You do not have to worry about that’. And you could see that without the input of this nurse, there were a lot of things that we were failing to understand in regards to this lady (patient). And when you don’t have that cultural understanding, you can slip into the mode that everything the person is saying to you is part of their mental illness. The (Pakistani) nurse did understand the Pakistani lady very well. She was like connecting two different cultures really”.

(Female 2nd Year Student, Interview)

In many cases however, this strategy is practically unfeasible given the potential shortage of bicultural or culturally informed mental health professionals (Willen,

2011). Furthermore, a potential problem of seeking the advice of a bicultural staff colleague is the sociocultural proximity of that staff member to the service user and their community. In particular, Willen (2011, p. 124) notes that the service user could become “concerned about the possibility that a clinician from within their community might divulge private and potentially damaging information to other community members”. Sociocultural proximity is a particular issue where “mental health care is stigmatized or sanctioned within one’s cultural community” (Willen, 2011, p. 124). Moreover, fellow staff members are not always willing to perform the broker role (Hannah, 2011). While some staff members may eagerly want to volunteer cultural information, others may not see this as part of their responsibilities.

Religious Group Spokespersons

The mental health practitioner may not be in a position to give an authoritative assessment on the normality of a religious experience and/or practice (Greenberg and Witztum, 1991; 2001). A religious ‘group spokesperson’³⁷ (Bonder, Martin and Miracle, 2002) may therefore perform the role of cultural broker and provide guidance on matters related to the ‘normative uncertainty’ evaluation dilemma (Lovinger, 1984; Charters, 1999; Loewenthal, 2007; Koenig, 2011). Thus, the distortion “of beliefs relative to the standards of the religious group” becomes the “crucial determinant of religious pathology” (Lea, 1982, p. 344). The DSM-IV (American Psychiatric Association, 1994) also urges mental health professionals to gain an understanding of the religious beliefs and value systems of their service users. Indeed, many religions endorse or encourage experiences that can be misinterpreted by the culturally unaware observer as the manifestation of psychotic symptoms (Loewenthal, 2007). Only one of the student nurse participants however, mentioned the value of seeking advice from a religious group spokesperson about the normality of a service user’s religious experience.

“A pastor did visit this lady (service user) on the ward-who kept reporting that she could see this guardian angel, which the doctors just assumed was part of a psychosis. I think the pastor came from her religious community. I think her pastor may have supported her actually in the appeals tribunal and was helpful in helping us clarify the normality of this lady’s experience. Thinking about it, he did come to the appeals tribunal about her sectioning and I think he provided some helpful input on

³⁷Religious group spokespersons usually work on behalf of a religious organisation and invariably have some form of authority in the religious community (e.g., Rabbi/Priest/Imam) and credibility outside the context of their group (Davis, 1994; 2000).

that. So her pastor's support was very important. I know that religion is quite a contentious point when people appear to be suffering from psychosis. As I do know that in some cases, it is hard to differentiate psychosis from a genuine religious belief. It is quite difficult to do that in practice. So her pastor was helpful in that regard".

(Female 2nd Year Student, Interview)

The three focus groups confirmed this general impression that there was little if any collaboration between mental health practitioners and representatives of outside religious organisations. In particular, the participants mentioned the problem of defining membership in the relevant religious group, and also raised concerns about protecting the confidentiality and privacy of the service user.

Female Student 1: *"I've never seen or done it myself and asked someone 'what's your local church? Do you know who's the person in charge at this time? Would you find it helpful to get in contact with them to see if they can come'? It's usually not their personal one... I mean like your personal priest. It would rather be someone sent from the trust".*

Female Student 2: *"I think I would want to see someone that I know rather than just the one from the ward that comes around..."*

Female Student 3: *"Yes, the one you've built a rapport with over the years. The one that knows what you used to be like and what your family is like, and how you normally are".*

Female Student 2: *"Rather than just someone that the trust perhaps decides to bring in and thinks is appropriate... I don't think I have ever seen where that is done though".*

(Pre-Registered Mental Health Student Focus Group N 1)

Female Student: *"It's probably because of like confidentiality and things like that. You can't just talk about those differentiation issues with a patient's religious person. You need that permission from your colleagues' and most importantly, the patient to do so".*

Male Student: *"I mean, I think it might just be a lack of understanding and information about that as well...Because you might not even...I don't think it's ever... It's never really occurred inside of training where someone has suggested 'have you ever thought of ringing up a church to'"*

(Pre-Registered Mental Health Student Focus Group N 2)

Nursing Educator: *"And then it comes back to that lack of information thing...That might have been what some of the problems about how to contact particular members from the service user's religious community. You know? Whether it's a Rabbi or a Vicar or some other type of religious minister... And not knowing which one belongs to which faith is perhaps part of the issue as well".*

(Nursing Educators Focus Group)

A lack of attention has been given in the academic literature to the actual form and parameters of partnerships between mental health practitioners and representatives from faith based organisations (Leavey and King, 2007). In a couple of the 'critical incidents', there was some evidence to suggest that mental health practitioners mistrusted or were suspicious of the intentions of the service user's co-religionists. Differing explanatory models (Kleinman, Eisenberg and Good, 1978) was a theme of these narratives.

"There was this lady patient on this acute ward. She used to attend spiritualist churches. Her religious beliefs very much framed her delusions and hallucinations. At times she got very distressed, as she would say that she could see poltergeists. At other times she would say that she was being possessed. It was very difficult in trying to preserve her sense of dignity too. I wondered how she was going to view her actions when she got better. She was going out at midnight to attend this spiritualist church. In the eyes of that lady's church, her behaviour is not necessarily viewed as being abnormal. According to her church that behaviour could mean that she is just a very spiritual kind of person. And she started to go to this spiritualist church more often. It seemed that the church was reinforcing and praising her behaviour. They did not see her psychotic experiences as indicating illness. The church perceived these experiences as spiritual occurrences. These experiences conveyed to them that this lady was a spiritual person rather than what we saw (the nursing staffs) as an ill person".

(Female Third Year Student, Interview)

"We recently had a lady who came in for a primary health care assessment, which I was assisting and helping out on. It turned out that she was part of a new church in the city and they were telling her....I think it was the 'New Life' church and she had recently just joined it. And the members of this church were telling her it was evil forces that were causing her illness and it can't be treated with medication, and it can't be treated with other medical help. Rather, it needed to be treated through prayer. So this church had a completely different perception than we did, and it was because she was a bad person that these things were happening to her. So she had come for a primary health assessment and was talking about her depression, anxiety, money worries, and how the church was now a big part of her life.

She was saying that the people at church will say 'that is the person who most needs praying for today'. So they would all circle her, point her out, and she would go into the middle of the circle and they would all pray for her. She has not been able to go back to church since they done this and they were saying that her illness was to do with evil forces. They were saying she should not be seeking medical help, which was for me as a student nurse quite difficult to accept. I can't remember the words she used, but they seemed to refer to evil forces that was in her and needed to come out. The way to do that was to pray, by praying to drive these evil forces out of her. So no, the church did not accept that it had anything to do with what we may call mental illness. And it made her feel really, really down and like made her feel worse

because it was as if it was her fault that this was happening to her. So I think sometimes religion might be a detriment. It might have a different view that it's not a medical view, that it's something that they've done wrong. And to me as a mental health student nurse that is not the case".

(Female Second Year Student, Interview)

Similar concerns were voiced by a nursing educator. The incompatibility of explanatory models was again brought to the fore in the nursing educator's narrative.

"I find that students and staff members find it a bit more concerning if someone is brought in from the outside. And I think that students worry about their religious practices and the potential impact on the patient. If they believe that the patient is experiencing religious themed delusions and they are trying to address that, I think they can be worried that somebody from a religious background will confirm or reinforce that delusion. Or the religious figure could undermine their clinical model for the patient's illness. Hospital chaplains³⁸ who are trained in mental health are considered as okay and acceptable, as they can deploy and understand the medical model of mental illness. I just think there is a perception among the students that people from the wider religious community will not have the same insight into a patient's illness as a mental health professional does".

(Nursing Educator, Interview)

Some of the 'critical incident' narratives collected for this PhD research, challenged the conventional assumption that dialogue between the faith sector and 'professional' sector (Kleinman, 1978; 1980; 1984) of mental health care will overcome barriers of mutual mistrust and result in collaboration on relevant clinical matters. As the cultural psychiatrist John Cox (1994; 1996) notes, this conventional assumption is too simplistic, as it ignores the underlying disjuncture between biomedical and religious explanatory models for the origins and resolution of severe mental illnesses. Indeed, Leavey and King (2007) question how a mental health practitioner could collaborate on clinical issues with a representative of a faith based

³⁸Multi-faith chaplaincy services increasingly have become common within the 'professional' sector of mental health services. Chaplaincy services may have important connections with and knowledge about local religious communities (D'Souza and Kuruvilla, 2006). The mental health care chaplain has been viewed as an 'expert' in the fields of spirituality, religion and mental health (Culliford and Eagger, 2009). Chaplains may be expected to provide the mental health team with advice on matters such as differential diagnosis and the controversial issues of spirit possession and exorcism (Dein, 2006b). Furthermore, chaplains can play a pivotal role in teaching health professionals about 'normative' religious practices and beliefs (Rattray, 2002). Dein (2004) has suggested that chaplains should undergo appropriate training in mental health if they are to effectively fulfil their role within the mental health team. Hospital chaplains in the UK receive some mental health training from the 'College of Health Care Chaplains' (Dein, 2010a).

organisation who believes that sin or demonic possession lies at the root of a person's illness, and therefore has no concept of its biopsychosocial causes. Conversely, when the mental health practitioner is ignorant or unaware of the relevance of religious frameworks for understanding the service user's experiences, seeking guidance from representatives of faith based organisations is unlikely (Cox, 1994; 1996). Thus, the nature and extent of collaboration between representatives of faith based organisations and practitioners from the 'professional' sector of mental health care can be discussed in the context of their use of differing explanatory models³⁹ for mental distress. Kilshaw, Ndegwa and Curran (2002) suggest, however, that it should not be a question of the practitioner sharing or having religious beliefs, "but in being tolerant about such beliefs and not automatically seeing them in a negative light or part of a pathology" (p. 97).

Summary

The reported ways of dealing with the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) that were presented in this chapter relate to the broad anthropological tradition of cultural relativism. In this tradition, the question of "what is normal versus what is abnormal" (Winkelman, 2009, p. 208) can only be considered within the local context of the person's (service user) cultural expectations and beliefs. Thus, familial and other important social relationships are critical to understanding the clinical significance of the person's experience (Kilshaw, Ndegwa and Curran, 2002). This is supported by anthropological evidence which shows that the self is not bounded, but develops as a result of several factors (White and Marsella, 1982; Seeley, 2006). One therefore sees the necessity of understanding the person's experiences within their local context. As Kilshaw, Ndegwa and Curran (2002, p. 98) note, when "the cultural context of the individual is considered, some problems that present with unusual religious or spiritual (cultural) content are, in fact, found to be free of psychopathology". This is not to deny the critical influence of the political economy of care and/or the professional culture of the placement setting on the dynamics of 'clinical recognition' (Carpenter-Song, 2011).

³⁹ Cox (1994; 1996) also suggests that collaboration on relevant clinical issues may occur when the 'explanatory models' of the religious representative include an awareness of the complex nature of mental disorders (and biomedical and psychological treatments) and the mental health professional has respect for the theological insights and healing ministry of religious organisations.

Practical and ethical issues, such as concerns around protecting privacy and confidentiality, or a lack of information about how to access representatives from faith based organisations, seemed to dictate decisions about seeking the advice of the service user's co-religionists or family members on matters of clinical assessment. In other cases, it seemed to be the incompatibility of explanatory models (Kleinman, Eisenberg and Good, 1978) which seemed to prevent collaboration between representatives of the service user's family or religious organisation and mental health practitioners. Thus, there remain important questions about the ways in which individual and cultural values intersect in these cases (Bonder, Martin and Miracle, 2002).

Conclusion

Introduction

This PhD research presented 'critical incident' (Fitzgerald, 2000) data on 'multicultural clinical interactions' (Fitzgerald, 1992) from pre-registered mental health student nurses' clinical placements. 'Multicultural clinical interactions' are a normal and everyday occurrence in clinical placement settings, yet the cultures at play in a particular interaction may go unacknowledged along with their clinical implications for the participants concerned. The exploration of the issues involved in 'multicultural clinical interactions' can bring these cultures to awareness and importantly, help in the development of strategies. In turn, these 'strategies' (Romiszowski, 1984) may contribute to making 'multicultural clinical interactions' more satisfying for practitioners (e.g., mental health student nurses) and service users alike. Strategies and problem solving skills for enhancing 'multicultural clinical interactions' must reflect the needs and challenges of mental health student nurses in their local clinical realities. 'Critical incidents' provided a rich and 'thick' (Geertz, 1973) descriptive basis for exploring these complex realities.

The content of this chapter is based around a critical reflection on the findings and my recommendations for undergraduate mental health nursing curricula, and future research on nursing, cultural issues and mental health matters. In the 'Reflecting on the Findings' section, I stress that one of the key lessons to be drawn from the 'critical incident' data about the 'normative uncertainty' evaluation dilemma (Good and Good, 1986) and its clinical implications, is that mental health staff should be encouraged to view the experiences of their service users in context. To realise this goal in practice means addressing the structural problems that constrain holistic assessment and treatment practice. It should also mean having to work towards changing some of the negative professional attitudes towards religion, which have tended to portray religious phenomenology and practice in psychopathological terms (Swinton, 2001; Kilshaw, Ndegwa and Curran, 2002; Tobert, 2007; Mohr and Pfeifer, 2009).

In the chapter section: 'Recommendations for Educational Practice'; I suggest that 'critical incident analysis' (CIA) in its current form and usage in nursing science curricula, could be usefully adapted to help student nurses to recognise the cultural dimension of mental health issues that occur in clinical placement settings. The conclusion chapter then finishes with a proposal for a focused needs analysis (Laird, 1985) to be carried out on the cross-cultural clinical assessment training needs of pre and registered mental health nurses and multidisciplinary mental health teams. Such a focused needs analysis could usefully inform the development of the adaptation of 'critical incident analysis' that I propose in the chapter section: 'Recommendations for Educational Practice'. I however, begin the conclusion chapter with a discussion of the overall strengths and limitations of the study.

Strengths and Limitations

The sample was taken from four nursing education centres, which were attached to one university in northern England; therefore, caution should be exercised in drawing generalisations from the study. In particular, it is acknowledged that the educational instruction and clinical placement experiences of the student nurse participants in this study may have been different from students at other universities and educational institutions. However, rather than trying to make crude generalisations or determining the frequency of particular cultural issues, the study goal and the main reason for using 'critical incident' (Fitzgerald, 2000) focused ethnographic interviews (Spradley, 1979) was to explore the rich complexity and contextual dimensions of mental health student nurses' 'multicultural clinical interactions'.

This study explored 'multicultural clinical interactions' in clinical placement settings from the perspectives of pre-registered mental health student nurses and their nursing educators, and therefore, it is based on their understandings of the interactions described. Other data sources, such as observations of 'critical incidents' in clinical situ or interpretations of the same incident from multiple perspectives (e.g., the service user and/or their family members), may have highlighted other important issues. The study however, does contribute new perspectives to the transcultural nursing literature. It explored participants' experiences of mental health student nurses' 'multicultural clinical interactions', as

opposed to prior transcultural nursing studies, which have focused their attention on the experiences of registered general nurses. To my knowledge, there have been no previous empirical studies, which have focused on the meanings of undergraduate mental health student nurses' 'multicultural clinical interactions'. Whilst some cultural issues can be expected to emerge across the different undergraduate nursing branches, each branch may present unique issues and challenges for students working in that particular area. Although the problems with linguistic barriers have been documented across the different disciplinary areas of nursing for example (e.g., Murphy and Clark, 1993; Osborne, 1995; Baldonado, et al., 1998; Kim, 1998; Spence, 1999; Boi, 2000; Gerrish, 2000; 2001; Cioffi, 2003; Narayanasamy, 2003; Ozolins and Hjelm, 2003; Cortis, 2004; Gerrish, Chau, Sobowale and Birks, 2004; Cioffi, 2005; 2006; Hultsjo and Hjelm, 2005; Berlin, Johansson and Tornkvist, 2006; Vydellingum, 2006; Peckover and Chidlaw, 2007; Pergert, Ekblad, Enskar and Bjork, 2007; Pergert, 2008; Tuohy, Mccarthy, Cassidy and Graham, 2008; Berlin, 2010), this PhD research showed that mental health nursing is based particularly on the assumption (Fitzgerald, et al., 1997a), that service users have a basic level of facility with the English language and understand the local cultural and social context.

Reflecting On the Findings

The 'normative uncertainty' evaluation dilemma (Good and Good, 1986) was at the heart of many of the 'multicultural clinical interactions' described by the research participants. To a large degree, these 'critical incident' (Fitzgerald, 2000) accounts were about a service user's religious beliefs, experiences or behaviours, and their clinical significance within the biomedical model of 'disease' (Eisenberg, 1977) and psychopathology (Offer and Sabshin, 1966). Some of the student nurse participant 'critical incidents' however, seemed to question the "privileged status" (Lock and Gordon, 1988, p. 7) of the biomedical model, which dominates the 'professional sector' (Kleinman, 1978; 1980; 1984) of mental health services, including the clinical practice of nurses. This was particularly the case where the student nurse participants were querying clinical assessments of 'insight' and/or assessments of religious phenomenology. In these cases, there seemed to be an explicit awareness that the biomedical model was not necessarily the 'correct' model for understanding and assessing the service user's experience. These participants recognised that the

biomedical model is another 'ethnomedicine' (Hahn and Kleinman, 1983), a "cultural construction with its own set of beliefs, assumptions, values, behaviours, biases, and sub-components based on a particular historical cultural tradition" (Fitzgerald, et al., 1997a, p. 85).

Considering the clinical implications of misdiagnosis (Minas, 1991) and the aforementioned clinical tendency to prematurely connect religion with psychopathology, all mental health professionals should be encouraged to bring their assessments of 'insight' in line with the DSM-IV's (American Psychiatric Association, 1994) recommendations on the cultural assessment of delusions (Saravanan, et al., 2004; 2005). Indeed, all mental health professionals should be encouraged to see the necessity of understanding their service users' experiences, including religious experiences and phenomenology in their local context. As Kilshaw, Ndegwa and Curran (2002, p. 98) cogently observed, when "the cultural context of the individual is considered, some problems that present with unusual religious or spiritual content are, in fact, found to be free of psychopathology". Similar criteria also could be usefully assimilated into other aspects of clinical assessment, such as assessment of 'function' (Mezzich, Caracci, Fabrega and Kirmayer, 2009).

Assessment is the focal point for subsequent nursing care, planning and intervention (Ash, 1997; Eeles, 2001; Eeles, Lowe and Wellman, 2003), yet assessing the clinical significance of religious phenomenology in particular was fraught with uncertainties and difficulties. There was a perception among some of the student nurse participants that these uncertainties and difficulties were a consequence of their lack of culture specific knowledge. Whilst student nurses and other mental health professionals clearly need to develop a foundational knowledge base in major religious teachings (Dein, 2004; 2010a) and basic cultural information (Fitzgerald, et al, 1997a), in order to inform their cross-cultural clinical assessments, a 'fact file' (Gunaratnam, 2007) and cultural deterministic application of cultural knowledge is best avoided. 'Factfile', or 'cookbook' approaches can separate cultural processes from individual and subjective experience (Dein, 2006a), and may contribute to clinical assessment errors (Tseng and McDermott, 1981; Stein, 1985; Minas, 1990; Fitzgerald, et al., 1997a; Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Stolk, 2009).

How does a student nurse or professional colleague understand cultural or religiously influenced phenomena, especially if they are from a different religious or cultural background, or have little interest in cultural or religious concerns (Loewenthal, 1995)? Encouragingly, the participants did at least report some situations from clinical placement where there was some attempt at assessing the clinical significance of culturally and religiously influenced phenomena. I would like to reiterate again, the importance of differentiating religious beliefs and experiences from psychopathology by their 'dimensional' characteristics, cultural influences, and impact on functioning (functioning assessed in cultural context [Mezzich, Caracci, Fabrega and Kirmayer, 2009]) (Pierre, 2001; Dein, 2012). The adaptation of 'critical incident analysis' (CIA) that I recommend for mental health nursing educational curricula in the next chapter section could be a useful way of introducing these problem solving strategies to student nurses.

I discussed in the literature review about how these questions and issues arising from the 'normative uncertainty' evaluation dilemma have been a central concern of the academic disciplines dealing with transcultural mental health and psychopathology, including cultural psychiatry and medical anthropology. However, to my knowledge, this PhD research is the first study to empirically identify this dilemma at the practice level of mental health student nurses. It is surprising and of concern that apart from Jennie Eeles (Eeles, 2001; Eeles, Lowe and Wellman, 2003) study, these issues have not concerned the mental health nursing research community. Do the mental health nursing academic and research community not see the 'normative uncertainty' evaluation dilemma as an important clinical issue? The 'critical incident' data from this PhD study and the cultural psychiatry and medical anthropology literature suggest that this may be the case (see Loewenthal, 1995; 1999; 2006; 2007; Dein, 2000; 2004; 2010a; 2012; Littlewood, and Lipsedge, 1997; Dein and Lipsedge, 1998).

It is of concern that this issue has not been touched upon by the mental health nursing research community, because the way in which the 'normative uncertainty' evaluation dilemma is attended to may have important clinical implications for the service user. In particular, the 'critical incident' data showed that clinical evaluation errors (Dein and Lipsedge, 1998; Andary, Stolk and Klimidis, 2003; Stolk, 2009) and

misdiagnosis may result in involuntary admission and temporary revocation of rights and freedoms. Inaccurate assessments, such as assessing cultural variations in phenomenology as psychopathology, are also associated with serious risks (Stolk, 2009). One of these risks is the long-term harmful effects of anti-psychotic medication on a person who is misdiagnosed as having psychosis (Lipton and Simon, 1985; Minas, 1991). Thus, this 'critical incident' material shows that whether an assessment is formulated well or poorly matters for both the care and treatment of service users (Good, 1996). These risks suggest that there now is an urgent need to investigate pre- and post-registered mental health nurses and other mental health professionals competence in making cross-cultural clinical assessments, and dealing with the issues presented by the 'normative uncertainty' evaluation dilemma. In the final section of this conclusion chapter: 'Future Research Suggestions', I make the case for a focused needs analysis (Laird, 1985) to be carried out on the cross-cultural clinical assessment needs and training requirements of pre-registered and registered mental health nurses and multidisciplinary mental health teams in the UK.

My data however, suggested some wider issues, which seemed to impede attempts at holistic assessment. In this conclusion, I have already noted the professional ideological issues, but there were also structural issues. Linguistic barriers and 'language discordance' (Sobo and Seid, 2003; Sobo, 2004; Sobo and Loustaunau, 2010) negatively impacted on cross-cultural clinical assessments in placement settings. This finding is consistent with the conclusions of survey studies (e.g., Minas, Stuart and Klimidis, 1994; Stolk, 1996; 2009; Baycan, 1997; Andary, 1998), which have examined the cultural responsiveness and training needs of mental health professionals and services. The student nurse participants repeatedly mentioned how verbal communication was intrinsic to the assessment process and for relaying information about symptomatology and emotional state.

These linguistic barriers were exacerbated by restricted access to professional interpreter services, which was explained largely on cost grounds. Although in many cases, participants mentioned that professional interpreters were used in psychiatric consultations, there were very few instances in the data where professional interpreters were called in to assist on nursing assessments, day-to-day clinical interactions, or therapeutic activities. Perhaps, this reflects the hierarchical structure

of mental health services, in which the work of the para-professions (e.g., nursing) is deemed of lesser importance or considered as supplementary to the core diagnostic and treatment tasks of the psychiatrist.

These problems persist despite multiple policy reports and recommendations (i.e., Department of Health, 2005) about the need for more professional trained interpreters and staff training in the use of professional interpreter services. There is also plenty of empirical evidence to suggest that a lack of shared language between service user and mental health practitioner can lead to inaccurate clinical assessment (Zalokar, 1994), and difficulties with problem identification (Fitzgerald, et al., 1997a). Alarming, the participants in my PhD study even mentioned instances where mental health staff minimised their interactions with non-English speaking service users, preferring to base their assessments on clinical observation alone.

Moreover, there seemed to be a general perception among the participants that heavy work schedules contributed to reductionist assessment and clinical practice. Clearly, student nurses and their colleagues in clinical placement settings need to be given the time to properly assess and contextualise the experiences of their service users. Indeed, Fitzgerald and colleagues' (1997a, p. 125) note that "time spent addressing cultural needs early can avoid more time-consuming problems in the future". Thus, the 'critical incident' material validates Carpenter-Song's (2011) important and cogent point, "that much of what mediates experiences and outcomes of health care falls outside of the dyadic interactions of patients and clinicians" (p. 180).

Recommendations for Educational Practice

The dissemination of the findings from this research may help mental health nursing education providers and teachers and their students become more aware of the interrelationships between cultural issues and mental health matters. However, the crucial question that needs to be posed is how this awareness can be built upon in nursing curricula and clinical practice. One possible strategy would be to introduce relevant clinical anthropological concepts (i.e., the 'explanatory model' [Kleinman, Eisenberg and Good, 1978]) and cultural issues through the use of 'critical incident analysis' (CIA) (Brookfield, 1990).

'Critical incident analysis' is widely used in nursing education (Cohn, 1989; Parker, Webb and D'Souza, 1994; Ghaye and Lillyman, 1997; 2000; Greenwood, 1998; Ghaye, 2005) for the purposes of illuminating professional reasoning and decision making processes (Cormack, 1983; 1996; Schon, 1987; Kemmis, 2004). Indeed, the student nurse participants in this PhD study were already familiar with using critical incident analysis to reflect on key aspects of their clinical placement experiences. Given its widespread adoption in the nursing sciences and students' familiarity with it, my proposal is that critical incident analysis could be usefully adapted to help student nurses to recognise and understand the cultural dimension of issues that occur in clinical placement settings. As the nursing anthropologist Geri-Ann Galanti (2008, p. xi) notes; "the most effective way to make a point is to tell a story". She goes on to explain that (p. xi):

"People remember anecdotes much better than they do dry facts and theories. Theories that grow out of stories are much easier to grasp and retain than ones presented in a vacuum because they create a sense of empathy and resonate with our emotions".

Already, the 'Intercultural Interaction Project' in the 'School of Occupation and Leisure' at the University of Sydney (Fitzgerald, Mullavey-O'Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O'Byrne, Clemson and Williamson, 1997) has shown that critical incident analysis⁴⁰ can be an effective educational tool for illuminating cultural and mental health issues, albeit in the training of occupational therapists.

Based on the academic literature (Brislin, Cushner, Cherrie and Yong, 1986; Brookfield, 1990; Mullavey-O'Byrne, 1999; Fitzgerald, 2000; 2001), I propose that there are several existing strategies for using critical incident analysis to enhance student nurses professional craft skills in the area of culture and mental health. Firstly, Fitzgerald (2001, p. 154) suggests that as a model and example:

"A critical incident can be presented followed by a previously developed detailed analytical discussion of the incident based on the published theoretical literature, one that might also draw on the presenter's professional craft and personal experience knowledge, to identify the cultural issues. In other words, the presenter would

⁴⁰ The 'Intercultural Interaction Project' showed that 'critical incident analysis' (CIA) can occur via one or more mediums of communication; including role play, storytelling, video, and textual analysis (Edwards, 1999).

present his or her critical analysis of the incident highlighting issues the presenter believes are important in that context. This is the approach commonly used in textbooks, research reports and classroom lectures. This would tell others what some of the issues are, and perhaps they could transfer this knowledge to another situation and use it to help identify cultural issues in other situations”.

For example, the nursing educator could select a ‘critical incident’ example of a religious type experience that is difficult to assess as being either culturally normal or psychopathological. The educator could then use this example with the student nurses in the class to identify relevant cultural issues (i.e., the ‘normative uncertainty’ evaluation dilemma) and possible strategies (Romiszowski, 1984) to help address those issues. However, as Galanti (2008, p. xii) notes, it is important to stress that “there is no easy ‘recipe’ for solving problems; each individual and situation is different”.

Secondly, the literature suggests (Brislin, Cushner, Cherrie and Yong, 1986; Brookfield, 1990; Edwards, 1999; Fitzgerald, 2000; 2001) that critical incident analysis can be applied as an experiential learning exercise (‘learn by doing’ approach), either as a focused discussion or critical reflection exercise. In these two approaches, critical incidents are pre-formulated⁴¹ from the clinical practice of others or based on students’ personal experiences of ‘multicultural clinical interactions’. While all these adaptations of critical incident analysis can be integrated into any subject within a nursing education programme, the analysis session itself, needs to take place in a culturally and psychologically safe context (Fitzgerald, 2000). All critical incident analysis sessions “involves confronting one’s cultural and personal beliefs, values and assumptions, and in many cases one’s past behaviours in similar situations” (Fitzgerald, 2001, p. 154).

Any such strategy would need to be carefully formulated through a multistage developmental process (Fitzgerald, Mullavey-O’Byrne, Twible and Kinebanian, 1995; Fitzgerald, Mullavey-O’Byrne, Clemson and Williamson, 1997) and undergo rigorous

⁴¹ A useful source for generating pre-formulated ‘critical incidents’ on the clinical significance of religious experiences, beliefs and practices is the ‘Religious Experience Research Centre’ (formerly known as the ‘Alister Hardy Research Centre’) at the University of Wales: Trinity Saint David. This research centre holds an extensive archive of first hand and contemporary accounts of spiritual and religious experiences, which is made accessible for scholarly and educational purposes. Indeed, the archive already has been utilised in studies, which in their different ways, have explored the clinical significance of religious and spiritual experiences (Eeles, 2001; Eeles, Lowe and Wellman, 2003; Tobert, 2007).

process and outcome evaluation. As part of this developmental process, consultation with academics and professionals from the mental health sciences, clinical anthropology, cultural psychiatry, and representatives from various faith and cultural communities would be required. Of course, the effective translation of critical incident analysis learning into clinical practice will require the right structural and professional conditions to be in place.

However, this educational strategy may go some way towards the debunking of the myth that mental health practitioners operate in what the medical anthropologist Janelle Taylor (2003a; b; 2010) described as a 'culture of no culture'. Indeed, the purpose of this adaptation of critical incident analysis is not only to help student nurses come to view others (i.e., service users) as cultural beings, but importantly, to recognize themselves and their professional culture as emergent cultural constructions (Fitzgerald, 1992). As Fitzgerald notes (2001, p.155), it is the recognition "that culture influences all aspects of health and illness, including interactions between health professionals and health professionals and their clients". Having been thoroughly evaluated in the nursing sciences, this adaptation of critical incident analysis could then be taken up in other health science professions.

Future Research Suggestions

This PhD research highlighted the primary cultural issues to emerge from mental health student nurses' clinical placement experiences. Having explored at least some of these core issues and identified how they were attended to or not attended to in practice, I argue that there now is an urgent need to study the cross-cultural clinical assessment needs and training requirements of student and registered mental health nurses in the UK. Although there are studies of the cross-cultural training and clinical assessment needs of mental health professionals in the Australian literature (Minas, Stuart and Klimidis, 1994; Stolk, 1996; 2009; Baycan, 1997; Andary, 1998), I could find no examples of research having examined similar issues with student and registered mental health nurses in the UK. I suggest that the proposed study could follow a similar design and approach to that of Stolk's (2009) focused needs analysis (Laird, 1985) of cross-cultural clinical assessment among 'Crisis Assessment and Treatment Teams' (CATTs) in Australia. In that, the

proposed study would attempt to identify what areas of cross-cultural clinical assessment UK based student and registered mental health nurses feel that their knowledge and skills are lacking in, and what are their cross-cultural clinical assessment training needs? By concentrating on the greatest needs or concerns (Stolk, 2009), such a focused needs analysis would help to ensure that recommendations about subsequent training in cross-cultural clinical assessment and 'critical incident analysis' are directly relevant to nurses in practice (Grant, 2002). As Shahnavaaz and Ekblad (2007, p. 15) note, the delivery "of adequate training programmes to health care staff requires that the providers (educators) have a good understanding of the targeted staff, their needs and clinical context realities".

The 'critical incident' data also highlighted the fact that mental health student nurses' 'multicultural clinical interactions' tend to not just involve service users and/or their therapeutic management group⁴² (Janzen, 1978), but invariably involve other nurses and professionals from different disciplinary specialisms (e.g., psychiatrists). Indeed, Shahnavaaz and Ekblad (2007, p. 27) observe that "in psychiatry, staff members with different cultural and social backgrounds usually interact across diverse disciplines, such as medical, psychological, sociological and nursing". I therefore suggest that focused needs analysis research could also be directed at identifying the cross-cultural clinical assessment needs and training requirements of multidisciplinary mental health teams in the UK. Kirmayer (2006, p. 126) in particular, argues that the "future of cultural psychiatry lies in advancing a broad perspective" where the multidisciplinary perspective takes a central place.

Summary

The conclusion chapter began with a discussion of the overall strengths and limitations of the study and some critical reflections on the research findings. I then suggested that 'critical incident analysis' (CIA) could be adapted to provide student

⁴² According to Janzen (1978), the 'therapeutic management group' usually involves a sick person's close kin and occasionally close friends, and may come into being whenever a person is faced with illness. Janzen goes on to describe the role of the therapeutic management group, as acting on behalf of a person when that person becomes ill, and rallying "for the purpose of sifting information, lending moral support, making decisions, and arranging details of therapeutic consultation" (p. 4). These decisions typically include making a diagnosis about the person's illness, selection and seeking of helping (healing) alternatives, and evaluating the efficacy of a therapeutic alternative (Helman, 1984).

nurses with some critical grasp of the interrelationships between cultural issues and mental health matters. More specifically, this adaptation of critical incident analysis would not only help student nurses to see others (i.e., service users) as cultural beings, but importantly, to also recognise themselves and their professional culture as emergent cultural constructions (Fitzgerald, 2001). This may help to dispel any myths that the 'professional' sector (Kleinman, 1978; 1980; 1984) of mental health services operates within a 'culture of no culture' (Taylor, 2003a; b; 2010). Such a training programme could be usefully informed by a process and outcome evaluation, and a proposed focused needs analysis of the cross-cultural clinical assessment needs of pre and registered UK mental health nurses. At least in the field of mental health nursing, this training programme would go some way towards reversing Suman Fernando's (2005, p. 433) observation that:

“Cultural psychiatry research and theory is now extensive, but as a body it is politically weak and has very little impact on training of professionals who by and large run the mainline mental health services in the UK”.

There is also scope for such a focused needs analysis to be extended to the cross-cultural clinical assessment training needs of multidisciplinary mental health teams.

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APPENDIX A

Written Critical Incident Guidance Sheet

Please can you write about any other specific situation with a patient during clinical placement where culture was important to that situation?

Can you please write about this specific situation using the following criteria?

- Please describe the situation by writing down when and where it happened (i.e., time of day and location).
- Can you please describe who was involved in the situation?
- Can you please describe what actually happened (i.e., who said or did what)?
- Can you please describe what you were thinking and feeling at the time of the situation and just after it occurred?
- Can you describe how you responded to or dealt with the situation?
- Can you describe what it was about this situation that was significant for you?

Please note that in accordance with the ethical protocols of this research, all data is treated as strictly confidential.

APPENDIX B



PARTICIPANT INFORMATION AND CONSENT FORM FOR PRE-REGISTERED MENTAL HEALTH STUDENT NURSES

Title of Research:

Cultural Issues in Pre-Registered Mental Health Student Nurses' Clinical Placements: An Anthropologically Informed Critical Incident Study

You are being invited to take part in a research study. Before you decide whether or not you would like to take part it is important for you to understand the aims of the research and what participation will involve. Please take the time to read the following information carefully. Please contact me using the details at the bottom of this information sheet if there is anything that is not clear to you or if you require more information. This research is being conducted by Andrew Bassett as part of his PhD in 'Culture and Communication' at Nottingham Trent University. The research is being supervised by Doctor David Kidner, a Senior Lecturer in Psychology at Nottingham Trent University. The aim of this research is to understand from your perspective the kinds of cultural issues that arise for you when working with service users during clinical placement and the types of strategies that you use to address these issues. Currently little is known about the actual impact of cultural influences on mental health student nurses' clinical practice. It is hoped that the findings from the research can help to inform nursing education, theory and clinical practice.

Participation in this study is entirely voluntary. You are not obliged to participate and if you do decide to take part in the research interview you can withdraw at any time without giving any reason or explanation. If you would like to take part you will be given a copy of this information sheet to keep and asked to sign a participation consent form. You also do not have to answer any specific questions during the course of the research interview. With your permission the interview session will be

audio taped and transcribed to provide a full and accurate record of the interview. You can ask the interviewer to turn off the tape recorder at any point during the interview session. You will be provided with a copy of the interview transcript, which you can review and amend. If the interview is tape recorded the tape of the interview session will be destroyed immediately after transcription. If you do not wish the interview to be tape recorded, the interviewer will ask for your permission to take notes during the interview session. You will then be given an opportunity to review and amend the interview notes. At the end of the interview session the interviewer will ask you if you have any particular questions regarding your participation in the research.

Everything that you say during the interview session will be treated as strictly confidential. All records from the interview session will be stored in locked secure files, which can only be accessed by the investigator, Andrew Bassett. You will not be identified in any resulting publications or presentations which derive from this research. When you have read this information, Andrew Bassett the research investigator will discuss it with you at the beginning of the research interview and answer any questions you may have. If you have any questions at any time please contact Andrew Bassett. **Telephone Landline, 0115 922 8684; Mobile, 07902908630; Email, n0284265@ntu.ac.uk** Please keep this participant information form.

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

I have read and fully understand the information detailed in the Participant Information Sheet. I agree to participate in this research study having carefully considered all the information provided in the Participant Information Sheet. Any questions which I have asked have been answered to my satisfaction. I am fully aware that taking part in this research study is voluntary and that I can withdraw at any time without giving a reason. I understand that I will not be identified in any resulting publication and that all information provided in the interview will be treated as strictly confidential. I have received a copy of the Participant Information Sheet and Consent Form. I understand that if I require any additional information that I can contact the research investigator Andrew Bassett who will answer any additional questions.

Participant's Name.....

Participant's Signature..... Date.....

Researcher Obtaining Consent

I verify that I have given the Participant Information Sheet and Consent form to the interviewee.

Researcher's Name.....

Researcher's Signature..... Date.....

Any person with concerns or complaints about the conduct of the research study can contact the 'Graduate School Research Department' at Nottingham Trent University, 0115 848 6335, or Andrew Bassett's research supervisor, Dr David Kidner, Landline, 0115 848 3022, or email, david.kidner@ntu.ac.uk

APPENDIX C



PARTICIPANT INFORMATION AND CONSENT FORM FOR MENTAL HEALTH NURSING BRANCH EDUCATORS

Title of Research:

Cultural Issues in Pre-Registered Mental Health Student Nurses' Clinical Placements: An Anthropologically Informed Critical Incident Study

You are invited to take part in a research study. Before you decide whether or not you would like to take part, it is important for you to understand the aims of the research and what participation will involve. Please take the time to read the following information carefully. Please contact me using the details at the bottom of this information sheet if there is anything that is not clear to you or if you require more information. This research is being conducted by Andrew Bassett (BA, PGcert, MA, and MA) as part of his PhD in 'Culture and Communication' at Nottingham Trent University. The research is being conducted under the supervision of Doctor David Kidner, a senior lecturer in psychology at Nottingham Trent University.

The aim of this research is to understand from your perspective the kinds of cultural issues that arise for mental health nursing students when working with service users and the types of strategies that students use to address these issues. Currently little is known about the impact of cultural influences on mental health nursing students' clinical practice. It is hoped that this research will help to identify these cultural issues and in doing so, inform nursing theory, education and practice. Participation in this study is entirely voluntary. You are not obliged to participate; however, if you do decide to take part in the research, you can withdraw at any time without giving any reason or explanation. If you would like to take part, you will be given a copy of this information sheet to keep and asked to sign a participation

consent form. You also do not have to answer any specific questions during the course of the interview.

With your permission the interview session will be audio taped and transcribed to provide a full and accurate record of the interview. You can ask the interviewer to turn off the tape recorder at any point during the interview session. You will be provided with a copy of the interview transcript, which you can review and amend. If the interview is tape recorded the tape of the interview session will be destroyed immediately after transcription. If you do not wish the interview to be tape recorded, the interviewer will ask for your permission to take notes during the interview session. You will then be given an opportunity to review and amend the interview notes. At the end of the interview session the interviewer will ask you if you have any particular questions or concerns regarding your participation in the research.

Everything that you say during the interview session will be treated as strictly confidential. All records from the interview session will be stored in locked secured files, which can only be accessed by the investigator (Andrew Bassett). You will not be identified in any resulting publications or presentations which derive from this research. When you have read this information, Andrew Bassett the research investigator will discuss it with you and answer any questions you may have. If you have any questions at any time, please contact Andrew Bassett. **Telephone Landline, 0115 922 8684; Mobile, 07902908630; Email, n0284265@ntu.ac.uk**
This participant information form is for you to keep.

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

I have read and fully understand the information detailed in the Participant Information Sheet. I agree to participate in this research study having carefully considered all the information provided in the Participant Information Sheet. Any questions which I have asked have been answered to my satisfaction. I am fully aware that taking part in this research study is voluntary and that I can withdraw at any time without giving a reason. I understand that I will not be identified in any resulting publication and that all information provided in the interview will be treated as strictly confidential. I have received a copy of the Participant Information Sheet and

Consent Form. I understand that if I require any additional information that I can contact the research investigator Andrew Bassett who will answer any additional questions.

Participant's Name.....

Participant's Signature.....|..... Date.....

Researcher Obtaining Consent

I verify that I have given the Participant Information Sheet to the interviewee.

Researcher's Name.....

Researcher's Signature..... Date.....

Any person with concerns or complaints about the conduct of the research study can contact the 'Graduate School Research Department' at Nottingham Trent University: Landline, 0115 848 6335; Andrew Bassett's research supervisor, Dr David Kidner: Landline, 0115 848 3022 or email, david.kidner@ntu.ac.uk

APPENDIX D



FOCUS GROUP PARTICIPANT INFORMATION AND CONSENT FORM

You are invited to take part in a focus group discussion. The focus of this discussion will be based on the preliminary findings report from my PhD research: “Cultural Issues in Pre-Registered Mental Health Student Nurses’ Clinical Placements: An Anthropologically Informed Critical Incident Study”. Before you decide whether or not you would like to take part in the discussion, it is important for you to understand what participation will involve. Please take the time to read the following information carefully. If there is anything that is not clear to you regarding any aspect of this research or if you require more information, please contact me (Andrew Bassett) using the details at the bottom of this information sheet. This research is being conducted by Andrew Bassett, who is a PhD student at Nottingham Trent University.

Participation in this focus group discussion is entirely voluntary. If you would like to take part, you will be given a copy of this information sheet to keep and asked to sign a consent form. If you do decide to participate you are still free to withdraw from the focus group discussion at any time. In addition, you can withdraw any information you have given during the discussion without stating a reason for doing so. You do not have to answer any of the questions during the discussion. With your permission the discussion will be audio-taped. This is to provide an accurate record of what was said at the focus group discussion. If at any time you wish to turn off the tape recorder, this will immediately be done. You also will be asked if you would like a copy of the transcript of the tape recorded discussion. You will be given the opportunity to review and amend any part of your contribution to the discussion.

Everything that you say during the discussion will be treated as strictly confidential. All records from the discussion will be stored in locked and secured files, accessible only to the investigator (Andrew Bassett). You will not be identified in any resulting

publications or presentations that derive from this research. In addition, you will be fully debriefed following the focus group discussion. During the debriefing you can convey any questions or concerns that you may have regarding any aspect of the research to the investigator (Andrew Bassett). It is expected that the discussion will last up to 2 hours.

When you have read this information, the researcher (Andrew Bassett) will discuss it with you and answer any questions that you may have. If you have any questions at any time, please feel free to contact Andrew Bassett. **Mobile no, 07902908630; Landline no, 01323 488382; Email, n0284265@ntu.ac.uk** This participant information form is for you to keep.

CONSENT TO PARTICIPATE IN THE RESEARCH STUDY

I have read and fully understand the information outlined in the participant information sheet. I agree to participate in this focus group discussion having carefully considered all the information provided in the participant information sheet. Any questions which I have asked have been answered to my satisfaction. I am fully aware that taking part in this focus group discussion is voluntary and that I can withdraw at any time without giving a reason. In addition, I am fully aware that during or after the discussion, I can withdraw any information pertaining to me. I understand that I will not be identified in any resulting publication and that all information provided in the group discussion will be treated as strictly confidential. I have received a copy of the participant information sheet and consent form. I understand that if I have any concerns or require any additional information that I can contact the researcher (Andrew Bassett).

Participants' Name.....

Participants' Signature..... Date.....

Researcher Obtaining Consent

I verify that I have given the participant information and consent sheet to the research participant.

Researcher's Name.....

Researcher's Signature..... Date.....

Any person with concerns or complaints about the conduct of the research study can contact the 'Graduate School Research Department' at Nottingham Trent University: Landline, 0115 848 6335; Andrew Bassett's research supervisor, Dr David Kidner: Landline, 0115 848 3022, or email, david.kidner@ntu.ac.uk.