Psychotherapy in a Multi-Ethnic Society

I have worked a therapist for over twenty five years. During this time I have seen many practice innovations, pedagogic Shifts and attempts to ensure that psychotherapy enables human growth and development. Yet, have come to realise that despite all this, as therapists we have still to make progress in terms of our work with black and ethnic minority clients. This article represents a desire to focus on this issue, with particular reference to the needs of Muslim clients.

Introduction

In recent decades, concern has developed about inequalities in mental health and health care delivery between the ethnic majority and Black ethnic groups. Research (Fernando. 1995., Patel et a], 2000) findings have shown overrepresentation of Black groups, many of whom are from Muslim backgrounds, in the psychiatric system. Furthermore research has found that Black ethnic groups are more likely than the ethnic majority to be admitted to hospitals under compulsory sections of the Mental Health Act (1983), deemed to require urgent treatment and placed on locked wards. Black groups are also more likely to be diagnosed as suffering from schizophrenia, given high doses of neuroleptic drugs and less likely to be offered non-drug based treatment such as talking therapy. Black writers (Kareem & Littlewood, 1992: Fernando, 1995: Robinson, 1995) have highlighted this issue. Certainly, the diagnosis of psychiatric disorders, even if not carried out by white psychiatrists, is based on the ethnocentric knowledge base of Western medicine (Crawford, 1994) which lacks any detailed understanding of how Muslim patients religious beliefs influence their thinking about health, illness and treatment. Yet there are an estimated 1.8 million Muslims living in the UK (Muslim News, 1998).

Outside the spiritual sphere, psychiatry part of western medical tradition, attaches its explanation of human distress to an individuals biological body. It deals with the classification, diagnosis and treatment of those people and it determines psychological ill health based on a wide range of clinical symptoms. The person is seen in isolation from their religious, social and environmental factors. This idea is based on the philosophical concepts of Cartesian dualism (the secular idea that mind and body are separate entities) present in western cultures. Thus the total experience of the person is divided into various components, such as hearing voices', feeling depressed' etc. What this means is that other life events, such as belief in Higher Power, as in Allah, which plays an important part in shaping peoples' experiences and concepts, is systematically played down. Ultimately then, this implies that the part religion plays in understanding the meaning of human suffering is of little value in helping us understand the origins of human distress

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Psychotherapy and the Muslim Community

Major differences exist between Western and Islamic psychology (Frager, 1999). Traditional psychology assumes that the Universe is a material entity without meaning and purpose whereas Islamic psychology contends that the Universe was created in accordance with God's will and hence life has a purpose. In traditional psychology descriptions of human nature focus on human limitations and neurotic tendencies (clinical psychology) or on innate goodness and an essentially positive nature (humanistic psychology). According to Islamic psychology human beings are located between angels and animals and share both natures. The struggle is to encounter and overcome negative habits and tendencies. Western psychologists and psychotherapists hold that self-esteem and a strong sense of ego identity are important and that loss of identity is pathological. In Islamic psychology, a sense of separate identity acts as a veil between God and human being. This distorts reality and prevents us from knowing our true divine nature. The goal is to recognise the difference between positive and negative ego and to transcend living a life through the ego. Western psychologists assume that personality is a relatively unified structure whereas Islamic psychology considers the human being to be a diverse collection of tendencies many of which are related to different stages of evolution. Many factors stop Muslims from asking for help; in an ongoing study, I am analysing conversations with 235 Muslim clients on their views of mental health services. Six themes have emerged: mistrust of service providers, fear of treatment, fear of racism and discrimination, language barriers, difficulties in communication and culture issues.

1 Mistrust of service providers

I feel that they (service providers) will force me to stay in the hospital"

"They (service providers) have their own agenda and it is not necessarily about my well-being"

2 Fear of treatment

'The staff do not explain what they do or why I think they start by giving lots of medicines"

‘A lot of the stuff they do is not necessary
-and they do not let you go until they are satisfied’

3 Fear of racism and discrimination

‘They (service providers) expect me to be abused by my husband”

“I’m a young Muslim male so I’m expected to be violent”

4 Language barriers

“I can’t speak English very well and it is hard to get the staff to understand what I mean”

“Actually, I found it hard to understand the accent of the doctor”

5 Difficulties in communication

“The men sit close to me and I feel uncomfortable
- this is not acceptable in the Islamic way”

“Sometimes people try to hold my hand I realise that they want to make me feel better
- but I don’t”

6 Issues of culture

“They (service providers) see me in a hi jab (full Muslim covering) and don’t bother to ask me what is going on

“My heart hurts and they tell me I’m depressed

These themes are confirmed by recent research. McMillan (2005) reports that BME groups are more likely to experience compulsory admission, longer length of hospital stay and are more likely to be prescribed drugs and ECT than psychotherapy and counselling. Aitken (1998) also reports that once people gain access they may be exposed to institutional racism and culturally insensitive or inappropriate delivery of care.

Failure by mental health professionals to address racism and normalise difference can serve to make institutional racism invisible thus allowing discriminatory practices to go unchallenged (Drennan, 1999). Research highlights the fact that service users often get misdiagnosed due to a lack of linguistic and cultural understanding (Fernando, 1995).

Muslims generally hold that faith protects against ill health as well as helping to manage health problems when they do occur. The fact that Islam plays a major part in shaping the Muslim’s understanding, experience and expression in mental distress is well-documented (Ansari, 1992; Hussain, 1999; Badri, 2000). Amongst Muslims, there is a strong tendency to conceptualise illness as occurring according to the will of God (Allah), who is understood to be a higher power that cannot be perceived by the senses.

In Islamic psychology three essential elements of the human psyche (ruh (spirit/soul), nafs (self/ego), and qalb (essential heart)) are commonly considered to reside in the region of the physical heart, the location of emotional pain. Somatic symptoms hold a significant place in the Muslim cultural system since psychological and spiritual development is considered to take place in the qalb (Sheikh & Gatrad, 2000). Here the perception is one of the connections between “psyche” and “soma”, the multiple ways in which physical and psychological problems interact. Therefore, the distressed person primarily notices and reports somatic symptoms. Mental unrest is thought to be the manifestations of an incongruent heart - an unstable soul - that is lost and so has become distant from its ‘creator’, Allah. In this sense, a stable or sound state of mental health is a “well” or “true” or “clean” or “guided” heart that is calm and so is within the sanctions of Islamic teachings. A “rusted’ or “hard” heart is a symptom of chronic ill feelings and ultimately God’s displeasure. This state is described mainly as an aching heart, a trembling heart and pressure in the heart. While the head is the vital and animating principle, the heart / soul is the locus of thought, feeling, awareness and memory. One “thinks”, “becomes aware” or “recalls” in the heart (Al-Munafiqun 63:3; Al-A’raf 7:179). Thus, “illness” is the illness of the heart or body. This mode of articulation is not to say that thinking in the heart is emotional illiteracy (an inability to understand and communicate emotions adequately), but that it is thinking that is metaphoric and closely connected to feelings. This feature of expression is rooted in the Quran in Surah Al-Baqarah (2:10):

“In their hearts is a disease”

As mental distress in the practising Muslim community is generally expressed as moral transgression or the result of Divine Will, religious interventions or methods are frequently resorted to for healing. Fasting (sawm), repentance (taubah) and regular recitation (zikr) of the Quran are common features of the treatment and healing process. Thus, the belief in the treatment is closely tied with the belief about illness. Underlying this belief is the idea of regaining connection and intimacy with Allah and in the process enabling one to gain a cognitive grasp of their situation. This is expected to reduce motivation for sin and relief from distress, which leads to better health. This understanding is reinforced in the following verses of the Quran:

“Surely in the remembrance of Allah do hearts find rest” (Ar-Ra’d 13:28)

The Therapeutic Encounter

If mental health workers are to develop a deeper understanding of ways of life and death, they need to incorporate into their western scientific professional knowledge base some respect for the spiritual sanctions or maps that are being generated within the cultures of the people they care for From this standpoint, it can be gathered that learning about the concept of after-life' (known as akheerah in Islamic terms) and how it relates to some of the symbols within 'God-conscious' communities are useful starting points in increasing empathy and sensitivity towards these groups. In other words, working alongside religious discourses is a step towards realising the vision of the worlds of others. Writers from psychospiritual perspectives (Badri, 2000) say that because of the under-value of the religious paradigm, too much emphasis is now placed on 'cultural differences'. These are defined in terms of social, cultural and physical difference. Badri (2000) argues that the belief systems which underpin a culture and are an integral part of the religious paradigm should be given greater prominence. More importantly they point out how a Western world-view approach to understanding community mental health needs now to engage in dialogue and include the context of 'faith communities'. For many people, religious faith or spirituality can act as part of the holistic healing process. It can be part of finding that 'centre' - the balance - that gives calmness and peace, which is so vital to recovery. Spiritual principles and values need to be closely explored if mental health professionals are to really appreciate and work creatively with the richness of a community in all its facets.

Several authors have contended that practitioners' personal and professional values can influence a number of aspects of the therapeutic process. Any theory of psychotherapy or counselling incorporates heavily value-laden assumptions about people, the world and the process of helping. Such values consistently affect the practitioners' choice of therapeutic techniques.

Thus, conflicts may occur when clients and practitioners differ in their religious beliefs; therapists viewing the inclusion of spiritual/religious material in counselling as less important than their clients (Bergin & Jensen, 1990). Muslim religious clients report fear that their values will be undermined by secular counselling (Jafari, 1993). Inayat (2002) follows the journey of five Muslims struggling with what it means to be a Muslim in the aftermath of the twin towers episode. It is important to note the guilt that these Muslims feel as well as their desire to examine other injustices that have been committed in the name of Islam. The author argues that the atrocity in America highlights the need to recognise clients' who may benefit from counselling within a religious/spiritual framework, since such clients' face their own guilt by association with the perpetrators, as well as dealing with the anger of those around them. Furthermore, such clients may be engaged in a difficult process of renegotiating their identity as members of the Muslim community.

Conclusion

Research into black and ethnic minority health and mental health has been critiqued for a number of methodological weaknesses (Sashidharan and Francis, 1993). Although a number of researchers (Redfern & Dryden, 1993; Netto et al, 2001 Shall, 1998), have suggested that empathy and a positive therapeutic alliance are the most important factors in effective psychotherapy and counselling, it is clear that very little is known about how black and ethnic minority patients present their subjective distress. As a consequence, even less is known about how therapists interpret these communications. The time is right for a shift in emphasis that empowers therapists and clients to build a bridge of open communication so that commonalties can be shared and differences can be celebrated.

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Biographical detail

I received my PhD for work on the effects of bereavement of physical, psychological and immune functioning. I co-ordinate a counselling service dedicated to faith based
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