DIVERSITY

In 1994 a Regional Supervisors’ workshop on social inequalities led to the formation of a working party, which produced documentary guidelines on addressing issues of ethnicity, ‘race’, culture and gender during training. This was circulated to supervisors in North Trent and the following guidance notes have been developed for the trainee and supervisor information packs to incorporate feedback received. Many thanks to all contributors - we hope that your views have been adequately represented. As views on these matters differ, it is hoped that these notes will stimulate consideration of the issues, rather than act as a definitive guide. Ongoing discussion of the issues raised occurs in the Diversity and Public & Patient Involvement Discussion Group, to which all supervisors and trainees are invited. There are a wide range of resources and additional references available via the Resource Library and the Clinical Psychology Unit website (diversity link).

Ethnicity, ‘Race’ and Culture

Use of Language

The meanings of words are socially constructed and continually evolving, a process which invites a lack of agreement regarding the use of terms. The following views are offered for consideration in choosing terminology:

Ethnic Group

Members of ethnic groups see themselves as culturally distinct from other groupings in a society and are seen by those others to be so. Many different characteristics may serve to distinguish ethnic groups from one another, but the most usual are language, history or ancestry (real or imagined), religion and style of dress and adornment. Ethnic differences are wholly learned (Giddens, 1989, in Gillborn, 1990).

Ethnicity

The feeling of belonging to an ethnic group.

‘Race’

The biologist Reiss (1993), and the population geneticist Lewontin (1982) consider the term ‘race’ unhelpful when applied to humans. This term tends to be used to distinguish groups by phenotype - skin, colour, hair or facial features. Studies of allele frequencies in humans show that the variation between any two individuals is likely to be of much greater magnitude than that between groups. There is no scientific basis for the classification of human groups by the term ‘race’. Some people therefore choose to use the term in inverted commas.

Racism

This term is usually defined as incorporating the presence of prejudice and power. It may also incorporate the notion of discrimination. (Gill and Levidow 1989; Gillborn, 1990). By this definition, prejudiced, stereotyped images of whites held by blacks in Britain would not be regarded as racist because blacks as a group would not be seen as having the power significantly to alter the life experiences of whites. At a personal level, however, racism involves negative labelling and a belief in an association between negative attributes and membership of an ethnic
group other than one’s own. It may also involve a generalisation of this supposed association beyond first-hand encounters.

Black

Many people use the term ‘black’ to refer to people of different national, ethnic and religious backgrounds who are believed to share a ‘common experience of white racism’ (Mac An Ghaill, 1988). The use of the term was legitimised by people using it to refer to themselves. Some people, for example of mixed race, do not use ‘black’ to describe themselves, but do experience racism.

Asian

This term tends to be used collectively to refer to people whose families emigrated at some time from Bangladesh, India, Pakistan or Sri Lanka (possibly via Uganda, Kenya or elsewhere). Ethnic groups with different languages and religions may thus be lumped together under the blanket term Asian.

In this section the use of some terms has been offered for your consideration. You may wish to include consideration of other terms in choosing language for yourself.

Ethnicity and Clinical Psychology

Psychological Theories – Views of Psychologists in Trent:

“The theory which adequately addresses these issues (of racism) in psychology is very much in its infancy.”

“Intergroup violence and intergroup forms of subordinating others is rife in our society; clinical psychologists need to be aware of the elitist thinking that can arise from the formation of groups which have been given certain kinds of identity.”

“The social psychology of prejudice has been grossly under-explored in clinical training.”

“Many psychological theories based on the notion of the inferiority of certain ethnic groups are extant.”

Service Contexts

People classified as Asian are 50 times, and as African-Caribbean 36 times, more likely than those classified as white to be victims of racially motivated attacks (Pillay, 1993). Within the communities classified as Asian, men are likely to link their experiences with problems of racism and feelings of powerlessness, whilst women are most affected by cultural differences and resulting feelings of isolation (Beliappa, 1991).

Many clients suffer through double or triple jeopardy – growing old, having a learning disability, low social status and/or suffering discrimination due to sexual orientation or gender.

Analysis of longitudinal census data (Greenslade, 1991) indicates that the Irish have the highest standardised mortality rates of all groups in Britain. The Irish are the only migrant group whose life expectancy decreases upon arrival in Britain. A study by Cochrane and Bal (1989) showed that
people born in the Irish republic had twice the rate of admission of English-born and a 50% higher rate than the next highest group (African-Caribbean) to psychiatric hospitals.

People from some ethnic groups are more likely to be faced with poverty and deprivation. The experience of discrimination and powerlessness may have profound effects on well-being.

Many standardised psychometric tests are not standardised across a range of ethnic groups. In the state of California, the use of intelligence tests for the classification and tracking of African-American children is no longer permitted (Hilliard, 1992). Little progress has been made since Anastasi’s (1976) conclusion that, “culture permeates all environmental contacts. Since all behaviour is thus affected by the cultural milieu in which the individual is reared, and since psychological tests are but samples of behaviour, cultural influences will be reflected in test performance... Every test tends to favour persons from the culture in which it was developed.” (See, for example, Kaufman 1993, Maclachlan et al, 1995, Poortinga, 1995.) Poortinga concludes that key problems of bias analysis of psychometric tests cannot be solved by further sophistication of statistical procedures, suggesting that a broadening of perspective in the field of bias analysis is desirable.

The use of blanket terms can mask striking variations. Of children classified as ‘Asian’, 17.7% of Pakistani, 4.2% of Bangladeshi and 26.4% of Indian pupils gained 5 or more ‘O’ level passes in 1985 in ILEA ((Nuttall et al) in Gipps and Murphy). More recent data can be found in Gillborn and Gipps (1996).

The profession of clinical psychology attracts low numbers of trainees from some ethnic groups. In Tower Hamlets, assistant psychologist posts sometimes have been specifically advertised to recruit, for example, a Bengali-speaking graduate. Often the assistant would subsequently obtain a local training place and undertake placements in Tower Hamlets. This was valued as an enriching experience for the staff and client community.

The making of ethnic groups ‘distinct’ may help or hinder appropriate service delivery. Some consider that such definitions may implicitly enshrine such groups as strange or weird. On the other hand, the Irish community in Sheffield fought hard to win legal recognition as an ethnic minority group under the terms of the Race Relations Act (1976).

In addition to issues arising out of racism, presenting problems may also reflect the conflicts of growing up in a context of multiple values, perhaps more salient in children of multi-ethnic families or those experiencing different values in family and the wider culture.

Working with interpreters or translators may be essential and/or desirable. Working with an additional person in sessions may benefit from the development of specific skills and considerations (see Baxter and Cheng, 1996).

**Practical Approaches to Addressing Issues of Culture and Ethnicity on Placement**

The holding of different beliefs and values is not a feature of difference only between ethnic groups. The following ideas might be a focus of supervision:

1. Exploration of the supervisor’s, trainee’s and clients’ perceptions of their ethnic and cultural identities, values and beliefs, how these have developed and changed and how they affect, and are affected by, the clinical work.
2 Exploration of values associated with the role of ‘helper’ and ‘helped’ for supervisor, trainee and in cultural and ethnic groups. This might include patterns of referral.

3 Examination of the basis of psychological theory and how it might be associated with the cultural and personal history of its inventor(s).

4 Development of skills in finding out, rather than making assumptions, about clients’ values and beliefs.

5 Drawing on a range of cultural and ethnic beliefs in the process of thinking about the work or challenging clients from all backgrounds, e.g. “If you had been brought up to expect an arranged marriage, how would you have approached your relationship differently?”

6 Considering the effects on clients of core socio-political issues such as poverty, discrimination, racism, deprivation and exclusion.

7 Considering how one’s own values may make it difficult to retain a position of respect towards the radically different beliefs of some clients, supervisors or trainees.

Approaches More Specific to Issues of Ethnicity

The following may be useful:

1 Finding out about local organisations that represent the views of ethnic groupings, e.g. Equal Opportunities Service Users Sub-groups, Sheffield Irish Forum etc.

2 Finding out how many people from different ethnic groups use the placement psychology service, how this is monitored, how it relates to the distribution of the population and what actions are being taken by the service, in regard to equal opportunities generally and ethnicity specifically.

3 Exploring how beliefs and values may differ between ethnic groups by reading (e.g. references cited here, religious books and novels - although these may paint many different pictures), visiting relevant community centres and meeting with people who have knowledge of particular groups, considering how the results of such information seeking may only be general.

4 Finding out which local professionals are from different racial groups and how they might be involved in clinical work. Considering the need for, availability and appropriateness of interpreters (NB this may apply in other contexts, for example for people who have hearing impairments and whose communication relies on sign language).

5 Considering the relevance of political issues such as immigrant or refugee status and its implications for confidentiality.

6 Developing awareness of population standardisation samples and the derivation of norms for standardised tests, rating scales and inventories.
7 Considering the development of wider awareness and knowledge by attendance at relevant training courses and conferences and through the DCP Clinical Psychology Race and Culture Special Interest Group.

Gender

Use of Language

There is probably greater agreement between people regarding the use of language in relation to issues of gender than in relation to issues of ethnicity and culture.

Sex

This term refers to biological status within the categories male and female. There is room for confusion through the attribution of sex at birth arising from, for example, incompatibility of genetic status and physical sexual characteristics. Sex of assignment and rearing are generally found to be of much greater significance than anatomical and physiological factors in determining sexual identity (as male or female).

Gender

Gender is a social construct, which involves assigning specified social tasks, roles, norms or behaviours into the categories feminine and masculine. What is labelled masculine and feminine in a particular society varies with time (Goodrich et al, 1988).

Gender Stereotyping

Gender stereotyping is defined as taking place when certain attitudes, emotions and behaviours are viewed as being appropriate for one sex and inappropriate for the other. Some feminist and men’s movements arise when gender stereotyping is perceived to produce power imbalance and sexual inequality or inequity.

Gendered Use of Language

Historically, male pronouns have been used to refer both to the group of males and to the population as a whole. In response to the view that use of language can contribute to the perpetuation of gender inequalities, alternative approaches to the use of female/male pronouns and gendered language have been produced (BPS, APA) and might inform decisions regarding their use. See appendix.

Issues of Gender in Clinical Psychology

In most services there are gender differences in patterns of referral and in professional response patterns to men and women. For example, boys under the age of 10 are referred significantly more frequently to child and adolescent mental health services; women receive two-thirds of all prescriptions for psychotropic drugs (Ashton 1989). Also see Usher and Nicolson, 1992.
Gender stereotyping plays a role in how clients define their difficulties and what they are prepared to speak about. There may, for example, be more shame perceived in a man admitting to being hit by his female partner than in admitting to hitting her.

Issues of gender stereotyping may be even more complicated when working with gay and transsexual communities.

Psychological theories evolve in the context of prevailing social and cultural values, which include gender stereotyping. Theories may be adapted to validate the exclusion of one gender from privileges accorded to the other or to legitimise discriminatory practices.

**Practical Approaches to addressing Issues of Gender on Placement**

**General Issues**

You may wish to consider:

- Gender stereotyping in the local and wider culture and in the histories of supervisor, trainee and client.
- Consideration of patterns of referral to the service and service responses based on gender. Finding out how the service monitors referral by gender.
- Consideration of how one’s own and trainee’s responses to clients, colleagues and each other are influenced by gender and how to obtain a missing masculine or feminine perspective in same-sex trainee-supervisor pairs.
- Consideration of how a client’s view of the gender of the worker might affect the work.
- Inclusion of a focus on the dynamics of power and responsibility as connected with gender and the presenting problem, and in the work being carried out with the client.
- Observation of and reflection upon one’s own potentially differential responses to trainees, supervisors and clients according to sex and gender. This might include sexual attraction, arousal and sexual advances and how these might affect the work.
- Bearing in mind that the sexual orientation of clients, supervisors and trainees cannot be assumed.
- Finding out about services that are organised around gender, e.g. Women’s Centres, Rape Crisis, Men’s groups.
- Considering the interplay of gender with other cultural issues, for example, influences on referral patterns and the response of self and the service to a poor black unemployed man with a learning disability, compared with a white female solicitor.

**Issues Associated with Physical and Sexual Abuse**

The literature on abuse, particularly sexual abuse, suggests an increasing recognition of its prevalence in recent years. Sexual abuse of males is an even more recently recognised phenomenon and the relative dearth of literature regarding perpetration of sexual abuse against men may make it an area especially worthy of consideration and discussion in supervision.

The following may be material for discussion on placement:

- Consideration of current knowledge regarding the incidence, demography and gender-distribution of physical and sexual abuse.
• The influence on meanings made by the client of the psychologist’s behaviour in the context of their having previously been abused.
• Experiences of being with clients who, for example, may have been ‘sexualised’ as children and the range of emotional responses this may evoke (e.g. sexual attraction, distaste, fear).
• Ways of keeping oneself and the client safe and anxiety contained when addressing intimate and/or emotionally charged topics.
• Consideration of the impact of the personal experiences of physical and sexual abuse in the histories of trainee and supervisor, within the boundaries of what is appropriate for discussion in the supervisory relationship.
• Keeping an open mind regarding the feelings and beliefs of clients who have been subject to abuse and towards the nature of the work that might be useful for them.
• Consideration of how the trainee’s and supervisor’s values, beliefs and feelings might affect work carried out with perpetrators.
• Consideration that the notion of transference may be of particular significance in this context.
• Methods of ensuring the physical safety of the worker when the work is being carried out with clients with violent and/or abusing histories. Ways of remaining safe when such histories may not yet be known.
• Drawing attention to relevant policies and procedures of the employing organisation.
• Attending relevant training events.

USEFUL REFERENCES


**USEFUL CONTACTS**

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