RQ6: Do service providers more appreciate the need to be aware of a medical versus sociological approach to the treatment of mental illness to help take responsibility for gendered power?

Background and rationale

Cross-cultural differences in the stigma of mental illness

The stigma associated with mental illness is cross-cultural; people fear, shun, and denigrate those with mental illness in all cultures (Corrigan, Druss, & Perlick, 2014). In individualistic cultures some of this stigma is particularly associated with being perceived as weak, and in collectivist cultures some of this stigma is particularly associated with marring family reputation (Sawrikar, 2005). As collectivist cultures are hierarchal, CALD families ascent in community standing only when their family name remains intact. Mental illness brings that name into disrepute, and is therefore seen as shameful.

Somatising mental illness in collectivist cultures

To avoid shaming the family name, people from CALD communities with mental illness may somatise their symptoms of emotional distress (Ferrari et al., 2015). For example, they may present to a medical doctor with insomnia rather then depressive sadness. Transferring mental pain into physical pain becomes a culturally acceptable means of seeking help because it does not disturb the family name.

Accessing help from such highly educated professionals also aligns with the hierarchical nature of collectivist cultures; they are respected and esteemed, making seeking their help acceptable and their service and interventions valued. Migrants often move to Western countries to gain access to these esteemed opportunities that may not be in their country of origin to the same extent, forsaking cultural safety or accepting ‘second-class citizenship’ in the process. Such socioeconomic processes make medical intervention even more valued; medical practitioners symbolise the migrant’s success against the ‘sticky mud’ of racism. While accessing psychiatrists would necessarily imply admission of mental ill-heath, they are still highly esteemed medical professionals with the ability to prescribe medication if
required, and therefore work within a model that can physicalise mental illness and thus preserve family name.

In comparison to GPs and psychiatrists, psychologists, social workers, and counselors do not carry the same professional authority or reverence.\(^1\) As such, engaging with such ‘non-medical talk therapists’ may first require the referral of a GP, who can use their professional power to help allay any shame or stigma the mentally unwell client and their family fears, and which the veil of accessing medical professionals helps cover (Haboush & Alyan, 2013).

Talk therapists require the client to value their own feelings (and be verbally expressive about them; discussed under RQ4). In a family-based cultural context, valuing the needs of the ‘self’ over the needs of the ‘family’ requires a complete turning-upside-down of the fundamental and defining feature of collectivism. Within the additional lens of overt patriarchy and traditional gender roles, women are particularly vulnerable to social exclusion and shaming from the community or physical danger in the form of threats or actual harm from the immediate family should they disclose to a public community member their personal needs and experiences. The more they have internalised their self-worth as dependent on the fulfilment of social roles (‘I am a good person because I am a good wife, daughter, and/or daughter in law’\(^2\)), the harder it may be for them to value their right to psychological safety. Going through the process of discovering the benefits of being able to share their trauma and value their future wellbeing could come at the cost of breaking up the family; a risk they may be scared to face because family cohesion protects family reputation and is therefore in utmost need of protecting. Thus, it is an immense stretch of an expectation for a CALD woman to engage with psychologists, social workers, and counselors. Arguably, victims/survivors only access such forms of help when their life is under threat and/or no other family capital is available (perceived or actual) to provide emotional support.

**Talk therapists and sociological approach to mental illness**

Although talk therapists may be culturally challenging to access, they offer a critical component of the ‘healing process’ toward empowerment, resilience, and a survivor rather than victim identity: foremost, they do not physicalise the mental illness. Instead, mental ill-health is interpreted within a social framework as the result of social injustice. Sexism is centrally named; it is not overlooked or minimised. Although labels such as ‘post-traumatic

\(^1\) This trend is not just true within CALD communities, but all communities within Australia. This is at least given by the incomes that each of these professions can command.

\(^2\) Females in all cultures experience a burden of separating personal worth and fulfillment from social worth and fulfillment; grappling with the challenge represents a fundamental component of becoming a feminist. These processes are likely to be more pressured, intensified, and difficult within cultural contexts that strongly or overtly endorse traditional gender roles.
stress disorder’ (PTSD) legitimate psychological difficulties as a result of child sexual abuse, they also localise and individualise the problem and therefore responsibility or onus to address it within the victim, who also risks being labelled ‘crazy’ or ‘mad’ (Reavey et al., 2006).

Thus, a sociological approach to treatment acknowledges the gendered ratio of reported prevalence; higher among females by a factor of three to four times (Chen, Dunne, & Han, 2004; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Thornton & Veenema, 2015; and Wang & Heppner, 2011). It also acknowledges that the silence that surrounds child sexual abuse in all cultural groups protects and preserves the patriarchal status quo because perpetrators – vastly male – are systematically spared from being accountable for their crime.

Problems with a purely medical model

Physicalising mental illness has its place. For example, a common quote expressed by participants in mental health research is ‘I wish people reacted to mental illness the same way they react to a broken leg’ (Sawrikar & Muir, 2018). Such a widespread and unquestioning understanding that neurochemical processes do contribute to mental ill-health has immense capacity toward destigmatising mental illness. Indeed, a primarily medicalised approach may be in the best interest of a CALD female client victim/survivor because it may simply be too difficult for her to engage with therapies that take a sociological approach to treatment; which ask her to care for herself above that of her care for the family, and enough to actually and simply speak about what her needs are and experiences have been. Getting some help, in ways that are culturally acceptable, may be better than getting no help at all.

It is for this reason that this project took the position that the use of a sociological approach to treatment was not essential, but that awareness of it was. The use of a purely ‘medical’ approach combined with a lack of awareness about a sociological approach is seen to be an irresponsible use of gendered power and therefore problematic for meeting the needs of clients well. Lack of awareness of a sociological approach, especially among male professionals, both medical and non-medical, risks unintended abuses of gendered power, which would only give the client cause to withdraw from clinical engagement. Given how challenging it is for the CALD client to even access the service, it is a risk the service provider and their organisation cannot and should not afford.

Summary

Overall, it is seen that GPs are a critical point of referral. A CALD client victim/survivor is likely to present to a GP with somatic symptoms of mental illness. The GP would need to be able to recognise and respect when this is occurring, and arguably is higher among CALD GPs because of tacit cultural knowledge about the need to save face. All GPs would need
training in how to sensitively screen for a possible history of child sexual abuse. If abuse is disclosed, they can then refer them to other relevant professionals. If the mental illness is severe, psychiatrists play a critical role in being able to prescribe medication and thus provide relief from the symptoms of emotional distress associated with depression, anxiety, PTSD, borderline personality disorder (BPD), etc. In taking a primarily medical approach, they offer assistance to victims/survivors that are mentally unwell as a result of the abuse, help preserve family name if sessions prioritise discussion on specific psychiatric symptoms in need of address rather than the traumatic event itself, and help destigmatise mental illness. Psychologists, social workers, and counselors play a critical role in enabling a sense of agency among victims/survivors, who are given tools on how to interpret their thoughts and feelings and reappraise them in ways that can better wellbeing. They can also ‘sit with’ the victim/survivor in their narrative about their traumatic abuse and the social injustice – specifically, sexism – that allows it to occur, go mostly unpunished, and be intensified across the life span (sometimes to the point of ‘suffocating silence’; Shalhoub-Kevorkian, 2000) by social pressure to fulfill female social roles that expect and train her to deprioritise the self. While each type of service provider has a unique and vital role, it is critical that they are also aware of the limits of their profession and which others help address that gap, so that appropriate referrals best tailored to a CALD individual can be made. A summary of the key processes and variables is provided in Figure 8.

**Measures**

Program attendees were asked one question in relation to RQ6: **B.10** – ‘A ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse acknowledges differences in social power across groups in society (e.g. by race, gender, class, disability, etc.). That is, it tries to understand the individual client as a member of broader society. It is also known as a ‘social justice’ approach. Which of the following is true for you?’ Options varied from 1 = I believe that a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse is useful or effective because trends in society do play a substantial role in understanding an individual, 2 = I do not believe that a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse is useful or effective because trends in society do not play a substantial role in understanding an individual, and 3 = I am not sure; I would like to learn more about what a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse entails.
Figure 8: Summary of proposed relationships between types of service providers, medical and sociological approaches to the treatment of mental illness, and responsible use of gendered power

1. CALD female likely to present to a GP for help with mental ill-health (e.g. depression, anxiety, PTSD, etc.)

2. GP needs to be able to recognise and respect possible 'somatising' of mental ill-health (to help protect family name)

3. If CSA is disclosed (e.g. after screening), GP may need to allay any anxiety about seeking help from a 'talk therapist' (which exposes the mental ill-health and risks family name)

A. MEDICAL
Psychiatrists can relieve some emotional distress by prescribing medication for severe mental ill-health (e.g. BPD)

B. NON-MEDICAL
Psychologists, social workers, and counselors can relieve some emotional distress by 'sharing the load', and teaching tools toward empowerment and wellbeing

The use of a medical model without awareness of sexist social injustices that allow 3–4 times more girls to be sexually assaulted, remain silent, and prioritise family needs over her own, risks disengagement by and poorer clinical outcomes in a client who more than ever needs the correct conditions of the treatment system be in place by the time she arrives. The onus of awareness is higher among male professionals who could minimise or overlook this social injustice. Focusing on the symptoms of mental illness shifts responsibility for addressing CSA from society to the victim/survivor; it may help the individual but it also risks downplaying the larger social context in which she lives.

Engaging with professionals educated and trained in social justice curricular can help avoid the pitfalls of a purely medical model – which can localise the problem within the individual by shifting focus away from social factors that led to her mental ill-health in the first place.
Changes over time

Usefulness of sociological approach to treatment of mental illness

By cultural background of service provider

At T1, all but one participant responded to B.10, who instead said *I believe that there is no empowerment without social justice, however I am not sure if one approach is enough, maybe a combination?* (Baseline Survey_48). It is indicative of nuanced understanding, but also highlights the forced choice nature of the question, which was intentionally designed to ascertain the number of service providers willing to commit to beliefs about the utility of a sociological approach. Two participants did not respond to this question at T2.

**Figure 9:** Percentage distribution on beliefs about the usefulness of a sociological approach to treatment of mental illness by cultural background of service provider (T1 and T2)
As can be seen from Figure 9 (and Data Table G.5), very few service providers thought that a sociological approach to the treatment of mental illness as a result of child sexual abuse is not useful or effective (CALD T1 5%, T2 0%; Anglo T1 2%; T2 0%); most thought it was useful or effective, or were not sure and wanted to learn more first.

The proportion of CALD service providers who believe that a sociological approach is useful or effective increased from T1 (59%, n = 34) to T2 (71%, n = 15), and the proportion who would like to learn more decreased from T1 (36%, n = 21) to T2 (29%, n = 6). The proportion of Anglo service providers who believe that a sociological approach is useful or effective increased from T1 (68%, n = 36) to T2 (81%, n = 17), and the proportion who would like to learn more decreased from T1 (30%, n = 16) to T2 (19%, n = 4). These changes over time suggest that the program was effective in helping all service providers take further responsibility for gendered power in their practice.

**Relationship with cultural self-efficacy**

The results in Table 16 show that at T1, CALD service providers who believe that a sociological approach is useful or effective did not have significantly different scores to those who wanted to learn more about a sociological approach on cultural knowledge (t(53) = 0.60, p > 0.05; M = 3.7, M = 3.6 respectively) or sensitivity/respect (t(53) = -1.01, p > 0.05; M = 4.4, M = 4.6 respectively). Anglo service providers who believe that a sociological approach is useful or effective did not have significantly different scores to those who wanted to learn more on cultural knowledge (t(50) = 0.42, p > 0.05; M = 3.0, M = 2.9 respectively) or confidence to work with CALD victims/survivors (t(47) = 0.69, p > 0.05; M = 2.7, M = 2.5 respectively). These findings suggest that their cultural self-efficacy is generally similar, and that they only really differ in their confidence to commit to beliefs about the utility of a sociological approach when presented with a forced choice question.\(^3\)

It was also found that CALD service providers who believe that a sociological approach is useful or effective had significantly higher scores (t(53) = 2.03, p < 0.05) on cultural confidence (M = 3.4) than those who wanted to learn more about a sociological approach (M = 2.9). This finding suggests that CALD service providers’ confidence to work with victims/survivors of child sexual abuse is higher when their confidence to commit to beliefs about the utility of a sociological approach is stronger. This is interesting because it means that their understanding of child sexual abuse as a gendered crime patterned at the sociological level, rather than one that is localised to the behaviour of an individual within a specific situation, improves their work practice. It also seems to tell of a story of the CALD

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\(^3\) ANOVA tests were not conducted at T1 with service providers who believe that a sociological approach is not useful or effective, nor for data obtained at T2, due to the small sample sizes and therefore insufficient variability in the cells.
service provider becoming a feminist against highly valued traditional gender roles in collectivist cultures.

Finally, it was found that Anglo service providers who believe that a sociological approach is useful or effective had significantly lower scores ($t(50) = -2.47, p < 0.05$) on cultural sensitivity ($M = 3.9$) than those who wanted to learn more ($M = 4.3$). This finding suggests that Anglo service providers are more culturally sensitive/respectful when they are unsure about how useful a sociological approach may be for CALD victims/survivors of child sexual abuse. That is, there could be an underlying fear of being seen to judge highly patriarchal societies, and therefore a ‘pulling back’ on commitment to beliefs about the utility of a sociological approach. In doing so, they are striving to demonstrate respect for difference.
Table 16: Descriptive data on beliefs about sociological approach to treatment of mental illness and cultural self-efficacy by cultural background of service provider (T1)

<table>
<thead>
<tr>
<th>Cultural background</th>
<th>Sociological approach useful</th>
<th>Sociological approach not useful</th>
<th>Not sure/want to learn more</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>N</td>
</tr>
<tr>
<td>CALD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural knowledge</td>
<td>3.7</td>
<td>0.7</td>
<td>34</td>
</tr>
<tr>
<td>Cultural confidence</td>
<td>3.4</td>
<td>1.0</td>
<td>34</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>4.4</td>
<td>0.6</td>
<td>34</td>
</tr>
<tr>
<td>Anglo</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural knowledge</td>
<td>3.0</td>
<td>0.7</td>
<td>36</td>
</tr>
<tr>
<td>Cultural confidence</td>
<td>2.7</td>
<td>1.0</td>
<td>34</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>3.9</td>
<td>0.5</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural knowledge</td>
<td>3.4</td>
<td>0.8</td>
<td>70</td>
</tr>
<tr>
<td>Cultural confidence</td>
<td>3.1</td>
<td>1.1</td>
<td>68</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>4.2</td>
<td>0.6</td>
<td>70</td>
</tr>
</tbody>
</table>
Summary

- To avoid shaming the family name, people from CALD communities with mental illness may somatise their symptoms of emotional distress. Accessing help from highly educated medical professionals also aligns with the hierarchical nature of collectivist cultures; they are respected and esteemed, making seeking their help acceptable and their service and interventions valued. Migrants also often move to Western countries to gain access to such esteemed opportunities, making medical intervention even more valued; medical practitioners symbolise the migrant’s success despite the sacrifice of having to endure racism. While accessing psychiatrists would necessarily imply admission of mental ill-health, they are still medical professionals and therefore highly esteemed, with the ability to prescribe medication if required and therefore work within a ‘somatic approach’ to mental illness that preserves family name.

- In comparison, psychologists, social workers, and counselors do not carry the same professional authority or reverence. Thus, engaging with these non-medical ‘talk therapists’ may first require the referral of a GP, who can use their professional power to help allay any shame or stigma the mentally unwell client and their family fears, and which the veil of accessing medical professionals helps cover.

- Thus, the GP is seen as a critical point of referral. They need to be able to recognise when a CALD client victim/survivor is somatising their mental illness, respect that this is occurring to save family face, sensitively screen for a possible history of child sexual abuse, and if disclosed refer them to other relevant professionals.

- In taking a primarily medical approach, psychiatrists can prescribe medication that is able to provide relief from the symptoms of severe emotional distress, help preserve family name if sessions prioritise discussion on specific psychiatric symptoms rather than the traumatic event itself, and help destigmatise mental illness. In this context, getting some help in ways that are culturally acceptable, may be better than getting no help at all. She does not need to engage with therapies that take a sociological approach to treatment, and therefore explicitly ask her to care for herself as if that self-care was in tension with the care she has for her family; a challenge that may be just too great for her. In particular, it may be seen as a risk to breaking up the family, or she may be vulnerable to social exclusion and shaming from the community or physical danger in the form of threats or actual harm from immediate family should she disclose to a public community member her personal needs and experiences; pressures bore of traditional gender roles, which are intensified in collectivist cultures that overtly value them because they are seen to serve definitively prioritised family goals. Indeed, she may only access psychologists, social workers, and counselors if her life was under threat and/or no other family capital was available to provide emotional support.
• Thus, talk therapists are culturally challenging to access, but they are also critical for enabling a sense of agency among victims/survivors when given tools on how to interpret their thoughts and feelings and reappraise them in ways that can better wellbeing, and ‘sit’ with their narrative (a client-centred approach) about their trauma, abuse of power, and social injustice. That is, they can speak about and centrally name sexism, unlike in broader society that allows it to occur, go mostly unpunished, and intensify across the life span due to traditional gender roles that suffocatingly expect and socialise females to deprioritise the self. It is in not physicalising the mental illness that she is relieved from the burden of being labelled ‘mad’, and the cause of her own emotional distress which she is then responsible for addressing.

• In short, each type of service provider has a unique and vital role, but it is also critical that they are aware of the limits of their profession and which others help address that gap, so that appropriate referrals best tailored to a CALD individual can be made. That is, the use of a sociological approach to treatment is not seen as essential, but awareness of it is. The use of a purely ‘medical’ approach without awareness of a sociological approach is seen to be an irresponsible use of gendered power and therefore problematic for meeting the needs of clients well.

• Lack of awareness of a sociological approach, especially among male professionals (medical and non-medical), risks unintended abuses of gendered power, which would only give the client cause to withdraw from clinical engagement. Given how challenging it is for the CALD client to even access the service, it is a risk the service provider and their organisation cannot and should not afford.

• At T1, most service providers thought that a sociological approach to the treatment of mental illness as a result of child sexual abuse is useful or effective, and some wanted to learn more. Hardly any thought it was not useful or effective. After the program, the proportion of service providers who thought a sociological approach was useful or effective increased, the number who were unsure reduced, and the number who thought it was not useful or effective was nil. These findings contribute empirical evidence of the effectiveness of the program in further increasing their responsibility for gendered power within their practice. The study would need to be replicated with medical practitioners to examine how different changes across time are for them as a result of the program.

• Generally, the cultural self-efficacy of CALD and Anglo service providers who believe that a sociological approach is useful or effective compared to those who are not sure, is similar. Thus, they only really seem to differ in their confidence to commit to beliefs about the utility of a sociological approach when presented with a forced choice question.
However, it does appear that CALD service providers’ confidence to work with victims/survivors of child sexual abuse is higher when their confidence to commit to beliefs about the utility of a sociological approach is higher. In turn, this speaks of their journey of becoming a feminist against highly valued traditional gender roles in collectivist cultures. In comparison, it appears that Anglo service providers are more culturally sensitive/respectful when they are unsure about how useful a sociological approach may be for CALD victims/survivors of child sexual abuse. In turn, this speaks of a way of not judging highly patriarchal societies and therefore demonstrating respect for difference.