Introduction

The tragic murder of George Floyd in the United States in 2020 served as a pivotal moment, igniting a widespread societal reckoning with institutional racism and its impact on disparities in healthcare, education and criminal justice. One significant response was in the push for educational reforms, particularly in North America and parts of Europe. Within academia this involved a call to revise systems of belief and sets of ingrained assumptions that have dominated generations of thinking in the West, thereby exposing the inherent power structures that have reinforced the status quo. It also initiated the inclusion of voices, approaches and practices that had been omitted or overlooked. History cannot be undone but new narratives can be written that account for lacunae in scholarship. The uptake of this process, known as decolonising, is ongoing but its implementation within the academy has not been consistent either in effort or approach.

This book continues the decolonising work done in the pioneering field of cultural psychiatry and focuses on the UK context. Whilst research in this field seeks to problematise the monocultural Western and white perspective, advocating the need to look cross-culturally and interculturally, thereby preventing cultural dominance, this study actualises that perspective. It looks at the lived experiences of South Asian[1] psychiatrists in the UK who, as a matter of course, have had to shift between at least two distinct perspectives in their lives. For first-generation migrants who came to the UK from countries such as Bangladesh, India, Pakistan or Sri Lanka, this shift was most pronounced in the very different cultural settings of their home country and the UK, which informed their life journey. They experienced their formative years in their home country, where they also attained their medical qualifications. Migrating to the UK was motivated in many cases by a desire to improve their work prospects, but it also involved having to adapt to a completely new environment, undertake further training and begin working life. The process of settling in a new country was often undertaken with little support and involved juggling two very different cultures. For second and subsequent generations, there were numerous shifts in perspective between the culture of their family of origin, which can be described as their home culture, and the cultures present at school, work and other realms, which largely reflected those of the majority group.

These collective experiences have in common the understanding of cultural difference not at a distance, or theoretically, but embodied in complex and fluid negotiations between professional and personal identities. For these psychiatrists, cultural difference plays out in many experiences, including during the process of migration, during training, in

[1] Within the UK, people with South Asian heritage are also known as 'Asian' but, for the benefit of global readers, the term 'South Asian' is used instead.

interactions with patients and colleagues, and within other areas of their working life in the hospital, clinic, academy or other organisation that forms their place of work.

Cultural psychiatry recognises the need to diversify the discipline of psychiatry in order to cater to the needs of culturally heterogeneous and global societies. One of the long-standing problems with Western psychiatry before the introduction of cultural psychiatry was its Western-centrism and failure to recognise its biases. This led to the pathologising of cultural difference, especially in relation to people of colour. This monocultural approach needed to be revised to become critically reflective and cognisant of ethnographic perspectives on culture, which stress the importance of examining culture in the terms of the group being studied. This requires the evaluation of its methods and processes to ensure that it is fit for purpose in a global context. One of the objectives of this process has been the inculcation of cultural competency or capability within clinical practice, which has been implemented in various ways.

One of the ways in which knowledge and understanding of 'ethnic minorities (excluding white minorities)'[2] – to use a phrase recommended at governmental level that replaced the erstwhile term BAME (Black, Asian and minority ethnic) – can be deepened within the field of cultural psychiatry is by giving the platform to members of these groups. In postcolonial theory, foregrounding the perspectives of ethnic minorities is vital as this empowers groups and individuals within these groups to speak for themselves rather than to be spoken for.[3] From a practical perspective, this will improve understanding about mental health services because the latter will be informed by those within the same or similar cultural groups, who have more of a tacit understanding of their needs. And, given the ongoing challenges that South Asian people have with services, knowledge of this kind remains valuable.

Within the discourse of cultural psychiatry, it is often assumed in research when discussing therapeutic relationships that (1) the patient is from an ethnic minority background, often from a BAME group, and (2) by implication, the psychiatrist is white and from the majority group. The first assumption can be explained by looking at the evolution of cultural psychiatry, which developed to meet the needs of increasingly diverse societies, where diversity concerns people from non-white ethnicities. The second assumption is hugely problematic. It points to the very issue that cultural psychiatry has been trying to correct, that of the problem of normative white bias. The default assumption within research on cultural psychiatry of the identity of the psychiatrist as white leads to a grave oversight, namely the quite different implications that may arise if the psychiatrist is from a non-white ethnic minority background. These include issues that the psychiatrist might face when, for instance, treating patients from a background similar to their own in terms of expectations and boundaries. Or issues that may arise for this same psychiatrist in treating patients from a white background. It also fails to recognise what is distinctive about the contribution of the ethnic minority psychiatrist. The view that 'within a cultural framework the practitioner is not to be seen as neutral or scientifically objective, but an active player in the cultural exchanges, bringing to bear his or her own cultural knowledge' is an important reminder of the inherent dynamism of the therapeutic relationship (Bhui and Gavrilovic, 2012, 105). The psychiatrist can contribute *both* to the identification of needs *and* ways in

[2] See www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity.

[3] This idea is articulated in Gayatri Chakravorty Spivak's essay 'Can the Subaltern Speak?' (Spivak, 1988, 271–313).

which to meet those needs. They may be better equipped to be able to identify idioms of distress, deploy appropriate explanatory models and understand attitudes about mental health within the group(s) of which they are a member of – factors invaluable to culturally sensitive care. A recent article by Ana Antić (2021) recognises the contributions of psychiatrists from African, Asian and other ethnic minority backgrounds (of which she includes Eastern Europe), which she argues is needed to diversify the field of cultural psychiatry in what she calls 'the Age of Decolonisation'.

This discussion alone has highlighted a gap in the research that needs to be addressed with some urgency. Cultural psychiatry advocates for a culturally sensitive and reflective approach, with the dynamic being set up and inculcated by the psychiatrist-as-professional, but which doesn't account for the ever present white privilege that has serious implications for a non-white professional, for example, in the culturally white spaces of a hospital, clinic or the academy.

This book foregrounds the need to learn about the perspectives of ethnic minority psychiatrists, taking as its focus South Asian psychiatrists within the UK context. There are compelling reasons for choosing this particular regional group, not least their contribution to British healthcare, chiefly the National Health Service. Of all doctors currently registered in the UK, 29 per cent are of South Asian ethnicity.[4] A recent report states how South Asian populations have disproportionately higher rates of many psychiatric disorders and yet are less likely to seek help (Gnanapragasam and Valsraj Menon, 2021). This observation is not new. In their systematic review of experiences of South Asian service users in the UK, Riddhi Prajapati and Helen Liebling (2022) make the important point that in spite of policies and action plans designed to close the gap of mental health inequality, significant problems persist. Learning more about the reasons regarding the lack of engagement of South Asian populations in mental health services, as well as ways of addressing what needs to be done by individuals culturally aligned to these groups, is vital and will provide a more culturally nuanced understanding.

Thirteen psychiatrists were invited, via interview, to reflect on their experience of living with different cultural identities and the bearing this had on their working life.[5] The narratives of these psychiatrists, that present cultural psychiatry as self-reflexive praxis, form the metaphorical spine of the book. The psychiatrists are *not* talking about cultural psychiatry; they are actually *doing* it. Decolonising the curriculum is an ongoing process. It is only when the voices and experiences of those on the margins are made central and embedded within discourse that long-lasting change can be seen in history, politics and culture. Much work has been done to combat these exclusionary practices, which in philosophy is described as 'epistemic injustice',[6] but the endeavour needs to be ongoing. This book is part of that endeavour.

[4] This figure is the percentage of doctors with declared ethnicity who identified as Asian/Asian British, that is, excluding those who did not declare their ethnicity (4 per cent of total). www.gmc-uk.org/about/what-we-do-and-why/data-and-research/gmc-data-explorer.

[5] The terminology of 'living with' is deliberate and to be contrasted with 'identifying with'. Ethnic minority (excluding white minority) individuals may be assigned an identity by others because of their racialised difference and this may distort their own views about group identity. The idea of 'living with' accounts for this, makes fewer assumptions about their affiliation and will be developed in Chapters 4 and 5.

[6] See Kidd, Medina and Pohlhaus (2017).

Throughout this book, an interdisciplinary approach is endorsed that looks at critical concepts and themes within the humanities and social sciences and especially within the domain of critical and cultural studies, which pertain to cultural psychiatry and are relevant to South Asian populations. For the benefit of readers from different disciplines, key terms, ideas and concepts are defined and explained when first introduced and are contextualised within the overarching approach of decolonisation.