Working with Diversity: An Overview of Diversity in Contemporary Society and the Effect of This on Healthcare Situations

12

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Abstract

In this age of digital and social media, there is a need for a consideration of individual spiritual needs within the infinite forms of diversities found within any population in today's globalised world. Faced with the endless range of individualities, this chapter considers concepts, such as development of individual identities of culture, the dominant influences of cultural perception (such as media and politics) and the personal experience of intersectional processes in shaping personal needs, wants and notions of spirituality.

Abbreviations

BAME	Black and Minority Ethnic Groups
UK	United Kingdom
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organization

12.1 Introduction

The fundamental ethos behind encompassing spirituality within holistic nursing and all forms of healthcare is its focus on individuality and what has been described as a unique 'inner, intangible dimension' ([1], p. 1140) in which a person finds personal meaning and self-purpose. There is concern, however, that patients being

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admitted to hospital are not having their spirituality or faith needs met and may be suffering personal consequences as a result. In an increasingly diverse and complex environment, healthcare staff may find themselves not prepared for the resourcefulness such a role requires of them.

The consideration of the spiritual needs for the varying forms of diversities found within any population in today's globalised world, however, requires a mind shift from limiting identifications and conversations regarding cultural care. In order to grapple with the infinite range of individualities, a number of concepts, such as personal identities of culture, the dominant influences of cultural perception and the personal experience of intersectional processes, need to be considered in order to show their inextricable link in shaping human behaviour and self-identity.

12.2 Personal Identities of Culture

In order to understand any patient, a fundamental place to begin the process needs to occur within the nurses, themselves. By understanding how each one of us is part of our diverse population and how our cultural individualities develop and co-exist, it provides a basis of a more open and less judgemental perspective to seeing how we perceive our patients and their diversities.

12.2.1 Defining One's Cultural Self

The ideas around culture, regardless of their various definitions and purposes, all have in common a number of shared characteristics that add to the inescapability and complexity of the concept for each one of us. Culture is expressed through multiple layers of complexity. This complexity is often variably addressed in terms of 'levels' in sociological and anthropological literature. One example of this is by the seminal writer on culture [2].

At one level, tertiary culture occurs when it is recognisable and evident as an observable appearance. Ideas such as a dress code, a regional dialect, fashionable trends in healthy food or the manner in which people address each other [3] would be considered tertiary culture.

At the secondary level, culture is demonstrated when values are expressed by individuals and in their rationalisations as to why they behave the way they do. The core reasons for a certain person's behaviour will be either unconscious or purposefully hidden; despite what they may express are the intentions or rationalisations for that behaviour or what they would preferably like those reasons to be [4]. At this secondary level, culture becomes less explicit but manifests as underlying rules, such as those of jargon or the colloquial way a common language is spoken. It tends to be known to members of a group but not shared with outsiders.

The final manifestation of culture, the primary level, can be associated to basic underlying assumptions [5]. Underlying assumptions are an unconscious revelation of culture, and it is that which actually determines how individuals or groups

perceive, think and feel about themselves and 'Others'.[1] At this most implicit level, rules are embedded and taken for granted and, at times, even unexplainable by even that person or group. It is rarely spoken about, yet known to that entire group.

All the different levels of culture together influence an individual's behaviour and the interpretations of that same behaviour by 'Others'. Tsai [6] makes an important argument that although certain aspects of culture are overtly visible, their related meanings and reasoning remain invisible. Figure 12.1 illustrates the complexity of an individuals' culture by comparing it to an iceberg, in that what can be seen on the outside is restricted and does not reflect the values and personal historical influences that a person has experienced. This seminal idea of comparing a person's culture to an iceberg was originally utilised by Hall [2] but has incorporated some concepts around faith and spirituality for the purpose of this chapter.

So, a certain stance, behaviour or gesture in one society, which is deemed friendly, may be considered rude in another, as the underlying reason for the action is unknown to those who may find it offensive. In addition, Hofstede [7] also suggests that how we perceive ourselves, express and behave culturally is also influenced by the dimensions of individualism-collectivism within our own group. The idea of individualism-collectivism is the range of feelings, beliefs and behavioural intentions intrinsic within a group, related to the degree of independence or solidarity and expressed degrees of concern for others [8]. Therefore, some communities may see their individual role or place within the identity of a wider group, rather than as a singular experience.

However, ideas around personal or cultural self-identity are interchangeable either being an individual construct or a social construct. Cultural self-identity reveals itself as an interchangeable collective set of characteristics by which a person is recognisable or known [9]. These may be behavioural or a personal characteristic founded on the notion that it mimics someone else's characteristic.

Bringing the various 'levels' of culture together, in conversation, the individual cultural construct gives meaning to 'I' or 'me', while a more social identity supports that meaning and allows a person to speak of the 'we'. This supports the fact that an individual's cultural 'self-identity' is mainly unconscious and constructed by the context they find themselves in at that time. In other words, our behaviour and expressions of our cultural self are dependent on whom we are with, at that moment. It is sometimes overtly obvious but mainly subtle.

Our social identity also changes, modifies and adapts over time by being influenced at a personal level, genetically and socially [10], and externally, through history and politics and by the media [11]. The culture of an individual or group is never a static experience. Your understanding of the personal attributes you hold of yourself in society can be at times accepting or non-accepting of yourself and of 'Others' within your environment. The aspect of cultural self-identity that an individual chooses to identify their self with could be selected interchangeably, among others, from a social, psychological, ethnic, powerful or helpless persona or through

[1] 'Others' here represents anyone who we see differently from our group we are operating within at that moment. Thus, it could be personal, professional, ethnic, nationalistic, etc.

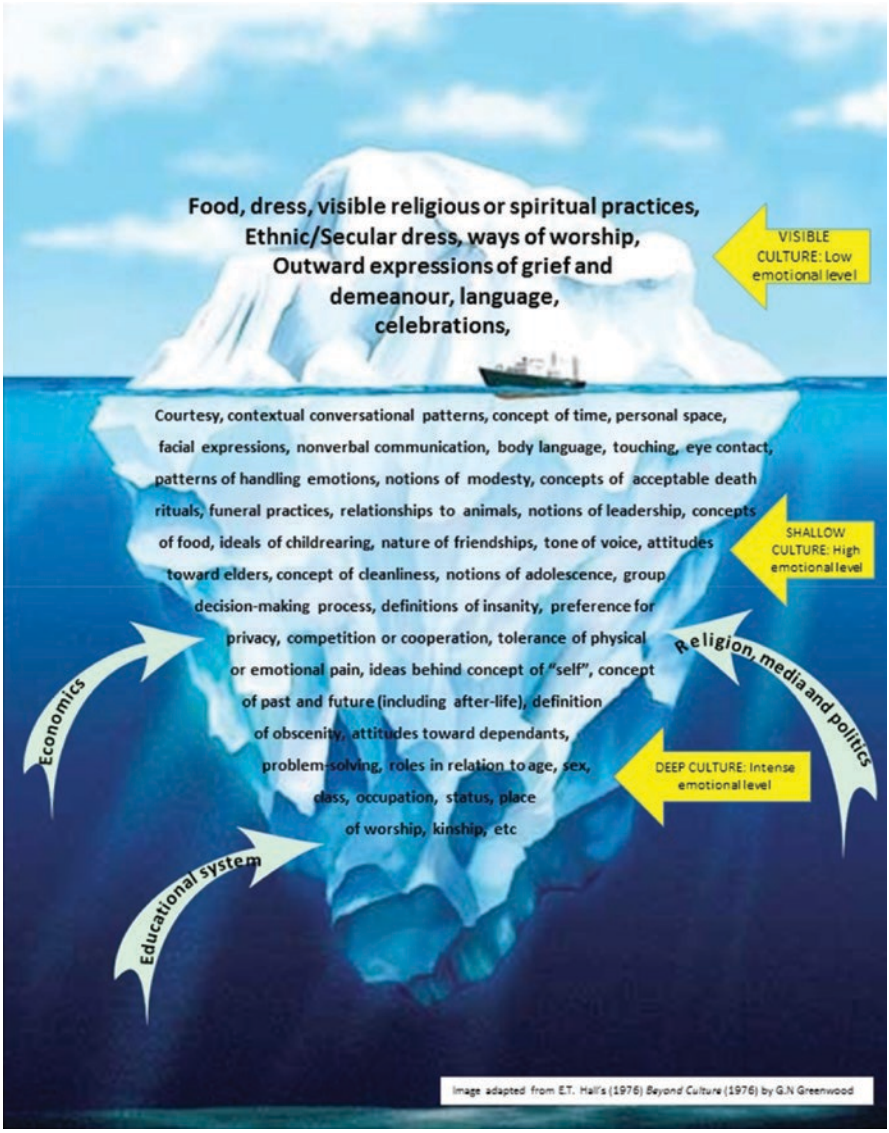

Fig. 12.1 Cultural Iceberg: visualisation of a person's visible and invincible culture

a gender or class label at the same time [12]. In addition, individuals and communities, due to the persistence of derogatory labels from external sources and stigma, can also, over time, internalise and adopt the negative self-identities assigned to them [13, 14]. An example of this can be seen in groupings such as 'gang culture'.

However, culture, in whatever form it takes or academic representation it originates from, is never an autonomous whole, uniquely distinctive or idiosyncratic.

Culture and cultural self-identity is porous. Factors such as the diffuse notions of identity [15]; the de-territorialised links between members of a group through resettlement [16]; and the varieties of rules, regulations and norms that guide verbal and non-verbal communication [17] together ensure its malleability to the individual person, at a point in time.

It is imperative to note that groups that appear overtly similar in terms of language and appearance cannot genuinely be considered monocultural because of the varying subtleties of the culture for each person. In any diverse and multicultural country, culture cannot only be a feature of Black, Asian and Minority Ethnic (BAME) groups [18] but the countless differences within the Majority population and groups beyond the limitations of race and ethnicity [19]. As early as 1958, Williams [20] was already expressing the intricacy of the nature of culture within all our everyday lives and stated that 'culture is ordinary': so ordinary that we do not see it until we are, one way or another, challenged by differences in what we expect and accept as the norm.

Another aspect that would cause the failure of addressing the spiritual needs of a diverse population is the lack of inclusion of the Majority population outside those who are considered to be diverse and at times, without cultural needs. It is too simplistic to look at changes in culture only from the perspective of changes to the BAME population, as people from all backgrounds adapt, change and evolve socially and culturally through time [21]. For example, since the 1950s, the Majority population in the United Kingdom (UK) has undergone a transformation in the way they see themselves culturally, among others, through a process of formalised legal changes in the country [22]. At that time, abortion and homosexuality became legal, capital punishment ended and measures were taken to improve the position of women and other minorities, economically, socially and politically. Regional cultures, habits and preferences, such as dialects, had previously been 'taught away' in schools [23] and rejected by the wider media. However, these idiosyncrasies have now developed into something to be proud of, reducing the perpetuation of the idea of cultural homogeneity or monoculturalism of the Majority population [24, 25]. Over a period of five decades, there has been a continued selection and adaptation of choices in customs or everyday practices such as food or festivals, between migrants and the Majority population, which has resulted in a form of 'hybridisation' of cultures [26].

12.2.2 Factors Influencing Culture

Generally, considerations around diversity and culture tend to be narrowed down to ethnicity, race, organised faith or religion and migrants [27]. This persisting narrative negatively affects discussions around diversity and on equality and fairness in healthcare.

The strongest influencers of culture are politics and history and are then perpetuated by the mass media [11]. Everyday political, mass media and historical conversations regarding culture tend to focus on BAME populations and their differences

from a unknown collective of 'us', mainly relating such comparisons to the Majority population.

Having considered the concepts that influence the diffuse notions of cultural self-identity, this section will look at how this awareness then affects how we consciously and unconsciously perceive those outside our cultural location. Also, the notion of the cultural 'Other' is necessary within this chapter, as the perceptions around this concept affect the way individuals distinguish between different forms of cultural identities, needs and associated social activity. Within this, nurses and patients perceiving each other as the cultural 'Other' will impact the relationship they will have and the expectations and delivery of spiritual care.

Piller [28] states that the sense of belonging (or otherwise) to a community has an effect on the way individuals or groups 'culturally' behave, perceive and communicate with each other. This cultural behaviour is part of the Majority population's self-identities and not just BAME populations. They also expressed that the question of difference is emotive: it promotes ideas about 'them' and 'us'; a sense of belonging or otherwise; membership or ostracisation from groups; and how to define 'us' in relation to others or the 'Other'. From this, we get ideas about communities, sometimes-imagined communities and even ethno-national boundaries.

The notion of the cultural 'Other' comes from an imagined idea of difference, either superior or inferior, to the cultural self-identity or social identities that may represent the norm [29]. Discussion about this concept is normally found in literature regarding racism [30], gender perceptions [31] and observations regarding disability [32], to name a few. The idea of 'Otherness' is central to the analyses of how Majority and BAME identities are constructed [33].

In childhood, identifying with the cultural 'Other' is a natural process of choice, towards those familiar and those our families identify and feel safe with. As we grow, the process of constructing or perpetuating a cultural 'Other' is amplified by subjective feelings of insecurity, chaos and vulnerability. Cleveland et al. [34] state that as a rule, the negative subjective feelings that are caused by social, economic and political concerns regarding 'Others' coming into a familiar group always result in some form of tension. These unconscious biases result in the ensuing struggles acted out by these groups or in the mass media and by politicians, with arguments inevitably being reconstructed around differences in cultural identities. Not unique to any community, from this emerges ideas that are ethnocentric, which is the root of racism. Ethnocentrism is the belief that your cultural or ethnic group remains superior to all other cultural and ethnic groups. With ethnocentrism, the acceptance or perception of all 'Other' cultural practices is compared negatively to your own. These challenges and arguments that surround cultural self-identity will be then made meaningful by a dependence on religious or ideological values, beliefs, myths and narratives and become framed within a general moral gauge of 'good' or 'evil' [35].

Another form of ethnocentrism is for a group to distinguish themselves as 'cultureless', thus normal. The personal perception that culture is 'exotic' and seen only

through the lens of festivals and different foods reduces the understanding of the intrinsic everyday feature of culture and diversity.

Although politically, in Western societies, the role of religion as a central certainty has been considered to have lost its cultural relevancy, it has, over the past few decades, become reimagined as a cultural symbol of identity, which further perpetuates the construction of 'self' and 'Others' [36].

With the massive acceleration of globalising trends in the past decade, including changes to economic interdependence and fears around mass migration, nations and national identities have been subject to considerable transformations that affect intercultural communications and behaviour [37]. Gallagher [38] feels that the construction of the cultural 'Other' had worsened in the past decade because of manipulation by politicians and a sensationalist media. Society, at large, looks for targets to vent their worsening frustrations on during times of economic stress. Studies as early as 2003, such as Miles and Brown [39], the UNHCR report [40] and, more recently, the UK 2014 National Social Attitude survey [41], had noted that it remains commonplace for politicians and the mass media to adopt a more nationalistic stance of intolerance, often to increase electoral popularity or to increase sales of publications through sensationalism.

Some examples of these have become apparent since the most recent European economic downturn of the past decade. It has become more familiar for politicians across the political spectrum and the media to make unguarded and unsubstantiated comments for their own gain [42, 43]. With this, the negative targeting of some British-born groups who share a variety of extrinsic traits with those undergoing this widely broadcasted negative scrutiny has been emerging, as they report experiences of a newer emerging discrimination previously not seen by them [44, 45]. Reese and Lewis [46] and Legault et al. [47] argued that this rhetoric becomes instrumental in our internalisation of what we see as the truth over a period of time and with it, our internalisation of what makes up the cultural identity of 'Others' and ourselves. McCroskey [48] referred to this as 'intercultural communication apprehension', where a fear or anxiety associated with either real or anticipated communication with people from different groups, especially cultural and/or ethnic groups' ([48], p. 148), becomes ingrained with a persistent rhetoric from politics and the media. In essence, people who have high levels of intercultural communication apprehension will innately have communication problems stemming from their fear or anxiety and limit communication with those who fit the idea of the 'Other'. The fears around intercultural communication, however, will be blamed upon society becoming more politically correct.

12.3 The Two-Way Process of Intercultural Communication

Theories of cultural care can often frame conversations with patients in an 'etic' way. An 'etic' slant to learning about diversity and culture utilises the worldview that would have originated from outside the culture being studied, looking

inward towards the patient approach. Taking into account the discussion in the previous section regarding the perception of how we may see ourselves dependent on what 'Others' may think of us, with an etic approach to appreciating diversities, the nurse remains outside the experience of providing spiritual care from his or her perspective, not the patients'.

What is more effective would be for the nurse to be aware with the impact of authority and establishment of trust as being crucial to the ease at which the communication process takes place, in a more 'emic' approach. Central to an 'emic' approach to the communication process is the aptitude of the nurse to be reflective, culturally self-aware and have the ability to listen to the patient's narrative in a non-ethnocentric manner. The nurse also needs to consider the impact of social and organise structures in enabling or inhibiting communication, cultural practices and health lifestyles. As such, they consider the provision of effective spiritual care, with the nurse keeping in mind individual differences, as opposed to providing care regardless of individual differences and seeing the 'Other' only as a member of a bigger group. Cultural care theories such as Papadopoulos' [49] transcultural health and social care model and Ramsden's [50] model of cultural safety specifically developed these 'emic' ideas within their frameworks, ensuring the nurse understands his or her role in inhibiting or promoting effective cultural conversations.

In addition to those aspects discussed in the last section that provide the characteristics of individuals' culture, there are two significant intersubjective factors that influence how we behave and interact with others. At one level, the varying determinants of health have a role in deciding the choices we are able to make to live our life in a certain way. Interconnected to this are our intersectional experiences of the determinants, which together influence how our patients are choose to interact with us.

12.3.1 The Social Determinants of Our Health

WHO [51] describes the social determinants of health as the conditions in which people are born, grow up, live, work and age and the systems put in place by their country, in order to deal with health and illness. As shown by the arrows underneath the iceberg in Fig. 12.1 which are the wider influencing factors, these circumstances are in turn shaped by a wider set of forces: economics, social policies and the political ethos of a country at varying points.

The way society at international, national or local level organises its matters gives rise to systems of social position and hierarchy. Although not unique, populations generally tend to organise itself according to income, education, employment, gender and ethnicity, among others. Where people are in the social hierarchy, this can affect the conditions in which they then grow, learn, and live and also their understanding, susceptibility and the consequences of ill health. All of these influence how they live culturally, how they perceive themselves and how they are perceived by others.

12.3.2 Intersectionality/Intersectional Processes

Intersectionality refers to those coinciding or intersecting shared identities and the experience of interconnected structures of discrimination that all of us may experience. Together, this can cause multiple layers of exclusion and influences the culture an individual adopts or exists within [52]. During any interaction, the nurse and patients' social and professional positions (such as gender, ethnicity, immigration status, personal journey, political and professional beliefs, biases, to emotional responses to patients, among others) unconsciously influence the way a two-way conversation takes place. This moves ideas around learning or caring for people in a diverse community, from just asking questions about personal preferences to a more therapeutic person-centred interaction.

Scollon et al. [53] and McIntosh et al. [54] found that health professionals needed to be aware of these intersubjective issues when communicating with a patient of any culture. They expressed the need for the nurse to listen without making prejudgements to them while being aware of issues around authority, hierarchy, status, and subordination and appreciating the symbolic and contextual impact of the conversation to the outcome of the meeting for it to be successful.

All communication encounters dynamically move between these areas in one conversation, as symbols and contexts of communication represent different things to those involved in the conversation [55]. However, considering all conversations involved more than one person, a nurse's exercise of authority, at times, could also work in the patients' favour where a conversation is stilted due to the participants' previous experiences. Reciprocal conversations, as Lindgren [56] stated, need to be productive and mutual, with the understanding that both sides bring their own histories with them.

12.4 Becoming Aware of Ethnocentricity and Intercultural Communication Apprehension

Developing cultural self-awareness is the foundation to reducing ethnocentricity and dealing with intercultural communication apprehension. A consideration of self-awareness 'crucially contributes towards one's understanding of the nature and construction of their cultural identity' ([49], p. 10). Engaging in a reflexive self-awareness, however, can be an uncomfortable exercise for anyone, as it requires people to be honest about previous errors, their ethnocentricities and personally held prejudices. Nurses with a lack of self-awareness about their own ethnocentric views or paternalistic attitudes can immediately stifle the communication process from being a mutually beneficial experience [57]. In addition, the belief that by just working in a multiethnic environment can develop the affective constructs such as cultural sensitivity, competence and desire could fail to manifest, if the management support for such an environment is absent [58].

The first thing to remember in this situation is that ethnocentricity and prejudice are universal behaviours: not unique to any community, country nor group of

people. We are all innately prejudiced. However, the lack of awareness of our strongly held worldviews, as superior to others has the potential to do unspeakable emotional and psychological harm to our patients. There needs to be a clear and honest discussion around how our professional values are affected by our personal values. Professional values may be the guiding beliefs and principles that influence work behaviour; however, it is inevitable our personal values and those ideas we have grown up with influence the conversations we choose to have or ignore the patient by.

It is important to note the completion of statutory strategies regarding diversity and equality cannot be seen as solution enough for improving our understanding about diversity. For example, diversity and equality training that is now compulsory for all UK National Health Service staff consists of the utilisation of online courses that concentrate on the law around equality and diversity. However, these online exercises do not take into account that completing a tool about being fair to 'Others' could add to intercultural communication apprehension as those participating can feel they are being judged, instead of a more time-consuming safe space to deliberate the origins of all our learnt prejudices.

Despite the personal responsibility of reducing ethnocentricity and becoming aware of intercultural communication apprehension, there needs to be a supportive, strong, safe environment and leadership for it to be effective in terms of patient care [59]. Within this, there needs to be awareness that reflection as a process can result in a greater suppressed self-determined 'prejudice regulation' if it not facilitated or managed effectively and done just as a 'tick-box' activity [60]. It results in nurses providing socially desirable or politically correct responses so as not to appear biased or prejudiced without any real critical reflection [61, 62]. Duffy [63] and Jirwe et al. [64] have found that nurses, nurse educators and health and social care professionals often avoid any form of analyses that challenge the dominance of Western political and cultural systems. Encouraging a safe atmosphere to reflect on the origins of our prejudices, which are present in everyone's behaviour, provides a more neutral starting place for all nurses.

Research by Nambiar-Greenwood [65] found that for both the participants from her study (from both the Majority and BAME populations) voiced their concern over how nurses, in their previous experiences, had unconsciously stereotyped or assumed their needs (or lack of need) by outward appearances or regional accents. The patients from the Majority population were not asked if they had any specific needs and the BAME participants in particular expressed the homogenisation of their overall culture.

Another factor that the participants of this study felt would influence the success or failure of understanding diversity was related to sensitivities surrounding conversations around culture in Western societies. All the participants from the BAME groups expressed that nurses are needed to be less anxious and be interested in questioning aspects of their culture that may be deemed sensitive, as a way of improving their illness experience. For example, two South Asian, Muslim participants expressed that nurses had adopted an oversensitive politically

correct stance, avoided questioning and made assumptions about their needs, which then made the provision of spiritual care for them ineffective.

This avoidance and anxiety of questioning is connected to the perpetuation of the mass media regarding BAME communities apparently becoming overly sensitive. This is where real or anticipated communication with people from different groups, especially cultural and/or ethnic groups, results in avoidance or stereotyping. These fears and anxieties could also be related either to personal fears of appearing offensive or discriminatory, perpetuated by the mass media [66], or to ethnocentricity [67].

According to Van Boven [68], the pressure to appear politically correct can have important consequences for the way people conduct intercultural communication. Despite private doubts, in order not to appear racist, sexist or culturally insensitive, a person (or community) could adopt a more defensive but socially acceptable reaction to what has come to be perceived as socially charged incidences. This pressure could lead to 'pluralistic ignorance': a situation in which a majority of group members may privately reject a norm, but incorrectly assume that most others accept it, and therefore go along with it [69]. The danger remains that this apprehension will reduce the ability of nurses to really listen or hear the patients' needs due to long-term held ethnocentricities and stereotyping prejudices.

Another issue with the ideas perpetuated around intercultural communication apprehension was that, as a reaction to not wanting to be perceived as racist or discriminatory, the nurse feels unable to challenge any behaviours of the service user, even if it is harmful to them [70] or unlawful [71]. Consequently, in some societies that have had more exposure to the notions of political correctness and the development of anti-discriminatory legislation, there is an experience of people feeling judged and fearful of being blamed for potentially sensitive subjects [72]. Individuals from both sides worry about how 'Others' view them as representatives of their social identity groups. They also feel inhibited and afraid to address even the most banal issues directly, such as questions about the correct pronunciation of the other person's name or culture. As a consequence, without really listening to service user's stories, private conclusions are drawn based on stereotypes, previous judgements and ideas perpetuated by the media, among others; then unconfirmed, these assumptions become immutable [73] and part of the information we use to care.

Central to challenging the insecurities surrounding the negative interpretation of political correctness or intercultural communication apprehension remains the art of effective questioning and listening. The assessment process at admission, despite having to pay attention to the immediate reasons for hospitalisation, needs to take into account their associated anxieties, their ideas of support and the factors beyond that illness that defined how they see themselves at that point.

Intercultural communication apprehension and ethnocentricity is, however, never a one-way process. Intercultural communication apprehension from the perspective of the service user also has an impact on the success of CAC being successful. Service users themselves, as unique individuals with unique horizons, bring with them their socialised or learnt apprehension to sharing their needs with the nurse. As Taylor et al. [74] stressed individuals from a more collectivist community, whatever their ethnicity may not be as willing to share their needs or problems with

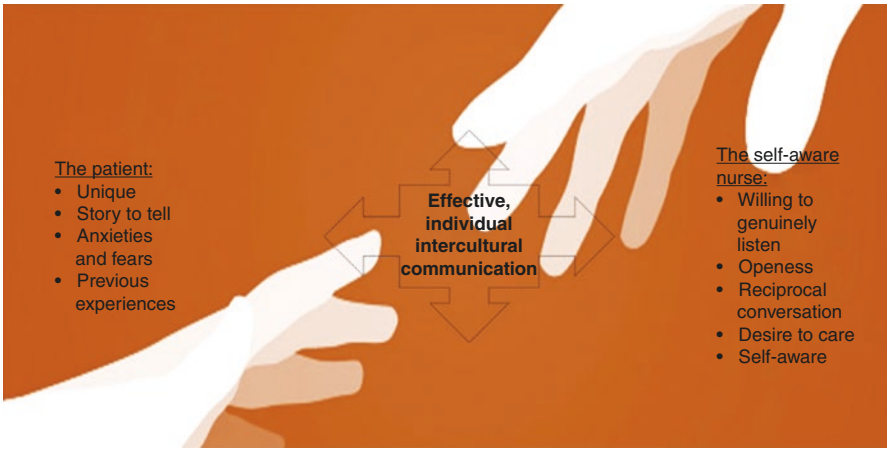

Fig. 12.2 A two-way reciprocal intercultural communication

the nurse. This may be because the person normally, within their community context, avoids bringing their personal problems to the attention of others or seeking support because of the perception that such an act can weaken the harmony of their bigger social group.

In dealing with our long-held ethnocentricities, and being aware of where our apprehensions in intercultural communication influence the way we communicate with a diverse society, it provides us with a more neutral foundation for effective intercultural communication. It allows us to hear our patients, with open mind to what they might have to say, need and want from spiritual care (Fig. 12.2).

12.5 Conclusion

Having an appreciation for diversity is not an experience or perspective that can be limited to extrinsic visible differences in individuals. The ability to provide effective spiritual care to a diverse community needs nurses and nurse educators to perceive it as a fundamental idea that has the ability to open up a holistic way of thinking about delivering individualistic care. The nurse needs to be able to see patterns of human behaviour beyond racial, ethnic, religious or social groupings. The nurse must be able to 'see' groupings culture in age, generation, disability, body image or varying types of mental illness. Within this, they also need to maintain flexibility by appreciating the construct of subcultures. Assessing diverse needs should not be extra or for 'special people'. It is not successful just by learning about 'Other' BAME groups' needs in terms of diet or prayer. This does not excuse the nurse from not learning about the differences and main tenets of the communities within which she or he works, but ultimately, the provision of spiritual care needs to be based on fairness and compassion for all patients, as we all have certain wants, needs and preferences during an illness experience.

Appendix: Scenarios

Travelling Family

Milly Smith is a 66-year-old woman who has just arrived in the A&E department with an exacerbation of her long-term chronic lung condition (chronic obstructive pulmonary disease), with a high temperature and dangerously low oxygen saturation levels (a pyrexia of 38.7 and saturated oxygen of 88%). She requires admission, for IV antibiotics and further care and investigations. Milly has been a heavy smoker (20–30 cigarettes a day) since the age of 10. She was diagnosed with this terminal condition approximately 10 years ago, and it has been recommended by a number of previous consultants that she access end-of-live palliative care services. Due to the transient nature of their lives, Milly has been unable to do so.

A devout Catholic, Milly was born into a travelling community and has moved around the United Kingdom and Western Europe throughout her lifetime. She and her family are currently based on an illegal campsite in the North West of England, and the local council is trying to evict the community from here in the next few days. She has 15 supportive adult children, between the ages of 24 and 51, the first child being born when Edna was 16. A widow of 4 years, Milly is very much a matriarch within her family and local community. She is accompanied in A&E by five adult daughters who are very concerned about their mum but express concern about her being admitted as it is likely that they will be moved on by the council in the next day or two. She is also distressed as they worship together on Sundays, in a shared communal way. The eldest daughter explains that her father died in hospital and the family experienced negative and racist treatment from the hospital staff.

1. What are the main issues that individuals and families who choose not to have a permanent address face in accessing healthcare? What can be done to facilitate her spiritual needs in this instance that makes her feel valued?
2. What are the differences between Gypsies, Roma, Travellers and New Age Travellers?
3. What issues may inhibit or limit how freely Milly and her family communicate with you?
4. How do programmes like ‘My Big Fat American Gypsy Weddings’ or other programmes that denigrate gypsy and traveller families influence our unconscious bias regarding Milly and her family?

Jewish Community

Joel Abrahams is a 48-year-old Orthodox Jewish man who has been admitted to a local psychiatric inpatient service due to an exacerbation of his enduring episodes of clinical depression. The nurses are reporting him not to be cooperative with any organised group work as he does show any interest in taking part in the activities

provided by the unit, such as watching movies, playing pool or the weekly exercise group. He is also particularly uncomfortable in taking part in any mixed gender group activity.

Joel has, during one of his previous admissions, mistakenly been diagnosed as having obsessive-compulsive disorder due to the psychiatrist not appreciating his religious practice of the concept of 'scrupulosity' and his desire for repetitive prayer throughout the day, accompanied by chanting and swaying. He also only dresses in the traditional religious manner of his community.

1. What are the factors that may reduce Joel's ability to communicate freely and effectively with health and social care staff?
2. What actions can be taken in relation to balancing Joel's religious or spiritual needs and the needs for the service for him to engage in activities that are alien to him and his daily life, his privacy and his dignity?
3. How does knowing about Joel's previous diagnosis of obsessive-compulsive disorder influence our unconscious behaviour/bias towards him?
4. What are the intersectional factors from Joel's perspective that influence his health?

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