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### Culture and Mental Health

**Suman Fernando**  
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#### **Prologue**

I have just 20 or 30 minutes for a complex topic so all I can do is to throw out some ideas, food for thought as it were. First I would like to refer to two terms- 'culture' and 'transcultural psychiatry'.

#### Slide 2: Cultural Diversity

When applied to an individual person, 'culture' generally subsumes the *non-material* aspects of everything that a person holds in common with other individuals forming a social group - child-rearing habits, family systems, ethical values or attitudes and sometimes religious beliefs or even language common to a group, what Leighton and Hughes (1961) call 'shared patterns of belief, feeling and adaptation which people carry in their minds' (1961: 447). When we say that Britain or Sri Lanka has many cultures – is multicultural - we infer that there are groups of people, cultural groups or 'communities', with different backgrounds, traditions and worldviews. So, in UK we talk of 'British-Asians', 'African-Caribbeans' 'Black-British' 'British Muslims' etc. and in Sri Lanka, Sinhala-Buddhist, Tamil-Christian, Muslim, Hindu, Burgher etc. But cultures do not exist in isolation (except very rarely) and are never static. They are dynamic, living systems continually changing. So a culturally diverse society may (for convenience and short hand) recognize 'cultural groups', but the reality is that the society as whole is culturally hybrid or mixed. So, when we say that British society or Sri Lankan society is multicultural we mean that they have a mixture of influences (in the case of UK) from Asian, African, Caribbean and other cultural traditions as well as the traditional 'European' cultures and, in the case of Sri Lanka, (say) from sources (traditions) that may be called Tamil, Muslim, Christian, Sinhala, Buddhist, Hindu, Dutch, English etc.

But we use the term 'culture' in a slightly different sense too when we refer to 'family cultures' or 'institutional cultures' (the culture of psychiatry for example) meaning, I suggest, the ethos or ways of functioning of a group of people with a particular background, occupation, profession or training.

#### Slide: 3: Transcultural Psychiatry

When you hear the term 'transcultural psychiatry' you may think of what were called 'culture-bound syndromes'. This term was given to syndromes recognized as 'psychiatric' but only understandable by fairly detailed knowledge of the people who exhibited the syndrome. Culture-bound syndromes were always found in non-western so-called 'exotic' cultures, difficult for westerners to understand. It is now only of historic interest. Today's transcultural psychiatry sees 'culture' as central to *all* syndromes not just to those that were considered strange or alien (from a western standpoint). The view from a transcultural perspective is that since psychiatry is located in western culture, reflecting values and an understanding of the human condition in that western tradition,

its application to people whose backgrounds are (broadly speaking) ‘non-western’ or in contexts that are not ‘western’ (e.g. in Asia and Africa), such application *across cultures* is fraught, unless special efforts are made to adapt it to be *transcultural*.

## **Introduction**

### Slide 4: Culture and Mental Health: Overview

What I propose doing now is to run briefly through the history of psychiatry and western psychology, the disciplines that underpin our concepts of mental health and illness in the western tradition. I call it *western psychology* because, unlike the case with psychiatry, one can (I think) recognize forms of psychology (the study of the mind) in non-western cultural settings too – Buddhist psychology, Hindu psychology, Sufi psychology and so on. But psychiatry is peculiar to the western cultural tradition in that a similar system is not discernable in other cultural traditions. In practical terms it combines together and draws from fields of human endeavor that are medical, social, spiritual, psychological, ethical, religious, and so on. Second, I shall try to examine, albeit briefly, some aspects of psychiatry and western psychology relating to health and illness from a multicultural perspective, pointing to the importance of so doing if services based on them are to be relevant and useful in multicultural societies, whether in UK, Sri Lanka or elsewhere.

## **History of Psychiatry and Psychology**

### Slide 5: History of Psychiatry

The serious medical study of human behaviour that led to modern day psychiatry emerged in Europe during the late sixteenth century when discourses in western philosophy came together with a medical interest in matters to do with the mind (Zilborg, 1941). *A Treatise of Melancholy* by Timothy Bright (1586) and *The Anatomy of Melancholy* by Robert Burton (1621) are examples. Medical psychology or psychological medicine (later called ‘psychiatry’) then developed: First, certain behavioural patterns and kinds of ‘mental states’ were attributed to disease meriting medical interest, rather than to such postulates as possession by demons, a state of sin, or wilful criminality; and second, there appeared the idea of the ‘mind’ as an expression of brain activity (Bynum, 1981).

It was against this background that the ‘great confinement’ (Foucault, 1967) started in Europe in the late 17<sup>th</sup> and 18<sup>th</sup> centuries when various groups of people considered deviant in one way or other were institutionalized. Medical psychiatrists, originally called ‘Alienists’ and later (in England) ‘mad doctors’, achieved a position of some power and influence by taking charge of these socially excluded people. Systems of diagnosis were developed using whatever information could be obtained including classical descriptions of illness by Hippocrates (Zilborg, 1941).

### Slide 6: Development of psychiatry

All this developed on the basis of the so-called Cartesian philosophy (attributed to Descartes who was influential in the 17<sup>th</sup> century) of a clear distinction between the 'spirit' (later defined as 'mind') and the 'body'. Mechanistic thinking of Newtonian physics was the order of the day. The disciplines of psychology and psychiatry gradually separated out. Illness of 'mind' fell within the domain of psychiatrists and study of 'normal' mind became psychology. The spiritual, religious and supernatural became excluded as 'unscientific', Matters 'mental' were studied by regarding human being as objects, rather than subjects, within the paradigm of 19<sup>th</sup> century science – positivist thinking, causality objectivism and so on.

Slide 7:           Paradigm of western psychology and psychiatry

I will not dwell on this. To cut a long story short, a variety of illnesses came into being reflecting western ideas of the human condition. Complex human problems (dealt with in other cultural settings as issues of philosophy, spirituality, ethics and so on) were constructed in western culture as medical illnesses, and then elaborated through observations from the basic sciences etc.

Slide 8:           Machinery of psychiatry

Morel's idea of degeneration (Morel, 1852) was rife in the late 19<sup>th</sup> century. Kraepelin used it to describe what he saw as the pathology of what became 'schizophrenia'. Nothing like it had been described as 'illness' previous to that nor had anything like it been described in other cultural traditions as illness or spiritual experience or whatever. (Degeneration was a sort of subhuman state that human beings were thought to fall into because of their inheritance.) The stories for depression and perhaps mania are different. One can see these in other cultures and historically they go back a long way in western culture.

Slide 9:           Social construction of illness

It is easy to see social construction of illness in the case of homosexuality (a disease until 1973 but not after that); or depression reported as rare among African and Asians people during colonial times when we were seen as lacking psychological characteristics such as 'sense of responsibility' (Green, 1904); or drapetomania, the disease which made slaves run away Cartwright, 1851); or cannabis psychosis, a diagnosis given almost exclusively to black people in Britain throughout the 1970s and early 1980s when the black man high on cannabis was seen as a threat to respectable British people; or hysteria as an illness mainly of women now seen as having been in positions of disempowerment.

These ideas and influences together with the economic and political pressures to diagnose 'illness' have resulted in a situation that, starting in the early part of the 20<sup>th</sup> century with a few categories of illness to subsume madness, yields today a myriad of western concepts being imposed across the world as illnesses with often western pharmaceuticals to 'treat' them.

You can see then that this sort of medicalisation of an array of human problems which in other cultural traditions would be seen (say) in terms of spirituality, ethics, philosophy and so on, must inevitably lead to a culture-clash in multicultural societies.

Two points need to be made here. First, this model of psychiatric illness seems 'scientific' (and so gets accepted) until one looks closely at it. Second, alternatives that may come about within (say) non-western medical systems allied (say) to non-western psychologies may be possible. But these systems have been suppressed and underdeveloped because of western domination and imperialism. And even today very few resources are put into these systems and they tend to have low prestige.

### **Conclusions**

I shall now take a pragmatic approach and see how transcultural psychiatry can have some practical value in service development, knowing the limitations of psychiatry, and realities of power.

### Psychiatry

Let us start from within psychiatry itself. Robert Kendell (2001), former president of the Royal College of Psychiatrists, who wrote extensively about diagnosis in psychiatry.

Slide 10: Psychiatric diagnoses

In a paper in the *American Journal of Psychiatry* three years ago Kendell and Jablensky (2003) say 'diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organising and explaining the complexity of clinical experience' (2003: 5). They argue that (unfortunately) diagnoses tend to get reified and 'people too easily assume that it is an entity of some kind.' (2003: 5). In other words, diagnoses in psychiatry are hypotheses and not objective facts; the question of whether we use them or not is a matter of utility and not validity. They are not 'things' out there that we can measure in any scientifically objective way – essentially they are a mishmash of judgments about people on the basis of what we assume to be 'good' or 'bad', derived largely from thinking in 19<sup>th</sup> century Europe and the science of that time, rather than modern science. Yet, this sort of illness approach to some problems *may* be useful – it depends.

The first thing for a transcultural psychiatrist is to question the usefulness of any diagnosis in the context in which it is postulated. Not necessarily to abandon it at the first hurdle as it were but to question it, understand its worth or disadvantage, what it means in the context of racism, of imperialism, of social pressures, of racism, of oppression and stigmatisation of people designated as 'mentally ill', of one's own values and those of the patient or client. Indeed its relevance to context in which one uses it. From there it is a matter of working out with the service user, the patient or client and their families, working out a common understanding, bringing in what we have learned in western psychiatry (including the benefits of medication) but giving precedence to the cultural norms and approaches of the patients and clients – and *their* experiences- and most of all to the social context that service users and psychiatrists find themselves in.

I suggest what we need most is a critical mind, a curiosity about what we may find strange, a skill to think laterally and openness to recognizing our limitations. It is the opposite of just following the rules set down by so-called experts and leaders and trusting blindly in whatever is put forward as ‘scientific’.

### Service development

Services for people with mental health problems in many low income countries, such as Sri Lanka, are to say the least abysmal. I know there are moves to try and tackle this at long last. Service development is a practical matter, and pragmatism must play a big part in one’s approaches. Balancing the need to persuade donors to pay for development is a political game as much as anything else.

A paper in a recent book has set down certain basic principles for service development in low income countries.

Slide 11: Developing MH services in low income countries. Basic principles

In the West, the past twenty years has seen attempts to undo the mistakes of the asylum movement of the 19<sup>th</sup> and early 20<sup>th</sup> century. So hopefully building asylums and allowing the ‘asylum culture’ – and this culture seems very much in evidence in Sri Lanka – allowing the ‘asylum culture’ to thrive should be the last thing in developing services. I shuddered recently when I read an article on the BBC website that quoted someone saying that a mental hospital in every town in Sri Lanka is being planned. Some sort of accommodation for people who are despised or excluded because they are seen as ‘mad’ may be needed, if only to prevent such people being tied up or whatever, but institutions should not be the main stay of mental health services. And if hospital-type accommodation is built then very strict minimum standards must be imposed, starting with the present institutions.

The starting point of planning must be how ordinary people perceive mental health and the sort of things they see as helpful, balanced of course by ethical standards and knowledge from what has been done elsewhere in similar communities. A trap to avoid is the mere replication *in toto* of what has been done in other places, especially in high income countries with good welfare systems, where the social system is secular (non-spiritual), etc.. Fortunately, there is now a considerable literature on developing mental health and social care services in low income countries. Also, of course NGOs in low income countries have had considerable experience in the social care field and could contribute to planning with ideas and practical help. I have tried to review some of this in a recent paper (Fernando, 2005).

The message is that mental health is primarily located in social systems and social care, with only a minor medical dimension. So, services should be planned essentially within a public health arena with an emphasis on health promotion through education and social interventions, rather than one based on a narrow western medical-illness model. In fact this is the way forward for low income countries that the World Health Organisation

proposes (WHO, 2001), although its representatives may not always practice what WHO preaches. Again, 'medical' and 'social care' in Asian and African cultures – and of course in Sri Lanka - includes indigenous healers as well as religious and spiritual sources of help. Planning mental health services must incorporate religious bodies and educational systems if the services are to be appropriate and relevant.

### **Summary**

In this paper I have presented briefly ideas about the inter-relationship of culture and mental health. I have done so by discussing the concepts, reviewing very briefly the history of psychiatry and the lessons from transcultural psychiatry. I have drawn some conclusions about practicing psychiatry in a multicultural setting and in planning and developing services in a largely non-western, low income country such as Sri Lanka.

END

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