Class 2 (19 October 2011). Critical Psychiatry and Psychology: Transcultural Psychiatry, Cultural Psychiatry, Anti-racist Psychiatry

The first slide is one I ended the last session with.

Slide: Problems of being culturally sensitive

Most people will agree that living and working in a multi-cultural society, and especially working in the mental health field - we need to be culturally sensitive. This is not always easy and often something we need to work at. The problem I suggest is compounded by racism. And here, what I mean mostly is not so much overt prejudice but more so institutionally sanctioned ways of going about our business, coupled often with forces that play on us all – our training, our pre-conceptions and the stereotypes we hold about other people, even ourselves sometimes. This is what is meant by talking of racism that is embedded in our institutions, the sort of behaviour often that we take for granted without thought. The most popular definition of institutional racism was provided in the Macpherson report on the aftermath of Stephen Lawrence's murder way back in 1993.

Slide: Institutional Racism

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people'

(Home Department, 1999: 28)

This was in the Stephen Lawrence Report in 1999 but in the very year of Stephen's murder in 1993 there was an equally important report on the death of Orville Blackwood at Broadmoor Hospital.

Slide: Blackwood Inquiry Report

Orville died from being given an injection of a mixture of drugs while in seclusion, having been put there ostensibly because he had refused to go to occupational therapy. There too 'subtle racism' in the mental health system was identified as the main issue that we needed to face up to but little notice was taken of that - the professional groups concerned and the Department of Health made sure that the report was virtually buried. The lesson is that facing up to racism in <u>mental health</u> services carries low priority – perhaps because '<u>the mentally ill</u>' are a stigmatized group of people anyway, and, it is difficult to accept that a <u>medical</u> system could be racist.

The concept of institutional racism is sometimes criticised because blaming 'institutions' appears to let individuals off the hook. So we must be clear that by referring to 'institutions' we are not talking of bricks and mortar but systems that are run by people – you and me – and of course the mental health system today includes many black and Asian people working in it. To put it bluntly, we ourselves are often involved in perpetuating the systems we work in and even sometimes in creating them. I was very conscious of this when I was practicing as a psychiatrist, when I came to understand <u>what</u> I was part of under a 'medical' umbrella. What one <u>does</u> about it then as an <u>insider</u> is not easy. I can refer you perhaps to a paper I wrote once to help me reflect on this particular dilemma; it is called 'Black People in White Institutions' - describing a situation I faced as a member of the Mental Health Act

1

Commission (Fernando, 1996); I think this paper is available on my website. There is no easy answer of course, once opting out is rejected, and each of us has to deal with personal dilemma in our own way, although I have personally found that support of colleagues is quite important. So just to remind you, the next slide summarizes the sort of problems that the mental health system has to tackle sooner or later.

Slide: Racial and Cultural Issues: Findings in England

Essentially, if you are black (as compared to white) you are between ten and twenty times more likely to be diagnosed as 'schizophrenic'; more likely to be sectioned under the mental health act – or since 2009 placed on community treatment orders; more likely to be deemed both mad and bad and so kept in forensic institutes such as Broadmoor; not referred to or accepted for counselling or psychotherapy but treated with drugs alone; and so on. I present these issues as being in England because most of the research has been done in England but there is little doubt that this is the scene in many western countries where psychiatry and western psychology dominate mental health services.

What then are the main impediments to change?

Slide: Impediments to Change

Much has been written about systems, and the difficulty of changing systems that have been running for many years and have become as it were the 'normal' way of doing things – the inherent conservatism of systems. Some professionals, including some psychiatrists, have hammered away for years wanting psychiatry itself to change in the way diagnoses are made and power exercised over people given particular diagnoses – especially of course schizophrenia. But as for changing the system we are expected to practice, we seldom get further than a sort of 'culture-speak' with little substance. Today it is almost fashionable – and politically correct - to claim to be 'transcultural' or 'cultural', but too often, I think, both names are misused and 'cultural sensitivity' used to avoid facing up to prejudice which is more about 'race'. And we carry on working from the narrow bio-medical, race- and culture-blind, variety of practice.

Several years ago I was involved in a series of meetings at the Royal College of Psychiatrists to work out how best the system of training of psychiatrists should change. This was incidentally a result of much lobbying and a supportive president. What we came out with was a sort of framework for a new curriculum.

Slide: Training in transcultural psychiatry

We agreed that the knowledge base (for psychiatric training) needs to be much wider than being drawn only from traditional western sources; and that psychiatrists needed to understand their own cultures and how to handle their own prejudices and preconceptions. They needed to acquire certain skills essential for dealing with a culturally diverse society. Above all, I think we agreed, that psychiatrists needed to know the limitations of the psychiatric system of diagnosis and to develop a humility that results in looking to other disciplines, such as anthropology and sociology, and, I would now add, to people who use mental health services.

As you see from the slide, this scheme for improving psychiatric training did not challenge the fundamentals of the discipline, but we hoped that it would set the ball rolling in the right direction. So did this get anywhere? Not really. Discussions were lost in series of committees and all that happened eventually (after some years) was that a black person was elected as

2

president of the college. Nothing wrong with that – a good message one might say as with Barak Obama's election - but it got nowhere towards changing the system of training and thence hopefully the experience of black people caught up in the psychiatric system.

This brings me to what is meant by 'Transcultural Psychiatry', sometimes called just 'Cultural Psychiatry'. Many of these matters were covered in the first master class on 5 October and so I shall <u>not</u> discuss the details, just present the slide for you to study at leisure.

Slide: Transcultural / Cultural Psychiatry

Transcultural Psychiatry basically means the acceptance that mental health and mental illness illness are largely determined by culture, which itself is not something static but dynamic and changing. Psychiatry and western psychology arose within a way of thinking – paradigm we call it – that developed in a western culture and so applying it as a system without much modification <u>across cultures</u> is fraught. Let's consider first the matter of diagnosis.

Slide: Diagnostic Misperceptions

Suppose that the current mental state examination (that psychiatrists are taught to carry out) is a sound way of assessing someone's ways of thinking, behaving and relating to others; and that diagnoses we make as a result are <u>useful</u> in indicating people's mental health needs. Then, the problem is that using something developed in <u>one culture</u> for people whose backgrounds are steeped in another <u>very different</u> culture results in what has been called (by transcultural psychiatrist Arthur Kleinman) 'category fallacy' – a mistake inherent in the system. This is a basic teaching of 'Cultural Psychiatry' – that culture is not just a <u>context</u> for diagnosis, something that one takes into account, but is central to diagnosis and to what goes for assessments that inform diagnosis.

The problem is clarified if you think (as Obeyesekere (1985), an anthropologist with an interest in psychology, writes) think of what happens if you take a group of symptoms identified in a traditional <u>Indian</u> setting – Obeyesekere refers (as an example) to the illness 'semen loss' characterised by weight loss, sexual phantasies and nocturnal emissions. If say we use this system to look for people needing treatment in America, counting the number of people who are ill and so on. One would, as Obeyesekere says – and he should know having been a professor at Harvard – one would be 'laughed out of court', because this combination of symptoms has <u>no meaning</u> (as illness) in a white American culture. But this is often what psychiatrists do when they diagnose across cultures in a standard way. But seldom are they ridiculed because the system <u>they</u> use is considered 'scientific', objective and so on but most of all because the system is <u>western</u> in origin. It is the <u>norm</u> to think western. As Ethan Watters, an American journalist says in the title to a recent book, it is assumed that everyone goes *Crazy Like Us* (Americans).

In diagnosis and assessments that we use across cultures, there is a clear <u>'culture-clash'</u> and <u>'category fallacy'</u> but the main issue is one of power and an arrogance bordering on racism. So 'cultural psychiatry' must, it is to be in the real world, move into being 'anti-racist', although many psychiatrists who call themselves <u>cultural psychiatrists</u> still shy away from addressing racism. In making assessments top down as it were, the professional's prejudices and assumptions are always bound to affect the conclusions – and these are about stereotypes, perceptions of what particular words such as 'psychosis' or 'schizophrenia' mean professionally (derived largely from the history of its construction) and so on. On top of all this of course is the political pressure today (especially with the changes in legislation

3

brought about in 2007) to put away and/or medicate people because they may be dangerous or a nuisance, and to give a diagnosis that enables this to happen.

What we should do primarily in making a diagnosis, whatever system one uses, is to connect with the person who is being diagnosed. The service user's perception of the problems - their narratives, how they see the world and its problems – these must be the starting point of a discussion that leads to an assessment. And making a list of the problems may be preferable to trying to subsume everything within one word or a set of standard words.

The psychiatric system that gives rise to a diagnosis and determines what happens to people given one is not simple.

Slide: Machinery of psychiatry in context

Various forces play on the people concerned in making assessments or diagnoses, especially the people who carry most power, usually the psychiatrist or psychologist, but increasingly in recent years other mental health professionals. The traditions they come from, the training they have received, information from various sources and what goes for clinical observations (which are basically judgements one makes about people's thinking, behaviour and inclinations). But it is the bit at the bottom of the diagram that is most important – the social and political forces, ideologies and assumptions that go into making up the 'culture of psychiatry' – and that is what underpins training, not just of psychiatrists but all professional groups in the mental health system. Much has been written about the vagaries of diagnosis not least by psychiatrists themselves, but in practice many people still attribute some sort of magical power to a diagnosis instead of regarding it as a mere convenience – a label - that may or may not be useful.

Slide: Psychiatric Diagnoses

This slide quotes what eminent academics defending diagnosis have said about the nature of psychiatric diagnosis as distinct from diagnosis in many other medical fields. Psychiatric diagnoses are not objective facts but hypotheses that may or may not be useful. Problems arise from the tendency to reify them into 'things' with a life of their own and a significance that they do not deserve. Their usefulness has to be examined continuously in terms of current social and cultural context. What I think is obvious at present in a multicultural society - in a world that is diverse in terms of needs and ideologies, in terms of cultures and races (whatever 'race' means) – what is evident is that some diagnoses at least should be dropped completely. I would opt for dropping schizophrenia in the first place. It is not just a barrier to people receiving proper understanding, a driver if stigma and quite useless for research but it has become a tool of racial oppression and exclusion from society of people who deserve much better.

Slide: Concept of Schizophrenia last?

This slide summarizes why schizophrenia should be dropped. Its construction under the aegis of movements in the late 19th and early 20th centuries (involving psychiatrists and leading to massive racial persecution) how it began is to say the least suspect. Now, it appears to be kept going largely because of massive investment of various types – to preserve the status of psychiatry as a medical discipline may be; certainly to provide a vehicle for publications that do not really further knowledge about mental health or show how people with difficulties in living can be helped. It is oppressive in practice and seems to be exacerbating, if not actually

4

promoting, stigma; and finally it is misleading when assumed to reflect biological illness (for which there is no valid evidence).

Abolishing 'schizophrenia', removing it from DSM and ICD, may well be difficult – as difficult may be as it was to remove homosexuality as illness in 1973. This time, the main problem may well be the investment it has attracted in real money terms via drug companies. But if we are to tackle the sort of problems I have drawn attention to in this talk and the last one, I think abolishing 'schizophrenia' and similar models inherent very often in the 'psychosis' concept - or at least diminishing their importance - is a must, if we are ever going to move towards racial and cultural equality.

Depression as a diagnosis, on the other hand, may not be such a problem.

Slide: Cross-cultural variation of depression

Depression - originally as melancholia - has a long history in western culture going back to Hippocrates and Islamic medicine. It has a sort of <u>openness</u> (that concepts like schizophrenia do not have) as a starting point for understanding a variety of problems of living – social, political, existential, biological and so on – and possibly has the potential of combining them all. But that is if the pressure from big Pharma to link it to drug therapy alone is resisted.

As individualized illness, there are three main lines to follow emanating from transcultural studies. First, one could see what is recognized in some cultures as an <u>illness</u> of depression as primarily a failure or loss, experienced according to the emphasis in the culture of <u>'self'</u> or <u>'non-self'</u>. Then loss may be felt as isolation; failure towards others as shame; and failure toward oneself as guilt. There is a wider theory that depression only occurs as <u>illness</u> in cultures that <u>'psychologize'</u> experience. Where somatization is the predominant mode, then other types of illness may occur. Finally the most attractive line of thinking is one devised by Gananath Obeyesekere, an anthropologist with interest in psychology. Here depression as illness depends very much on how the 'depressive affects' (sort of deep feelings) are dealt with in the person's culture. The example he gives is that in Theravada Buddhist culture (and may be in some cultures of West Africa) depressive affects are tied to issues of existence and so dealt with in a religious or spiritual mode, unlike in (say) American culture, where they are 'free-floating' or unattached and so identified as 'illness' requiring perhaps a medical approach. We know that while depression may be seen as illness in many western cultural contexts, it may be more of a spiritual or existential crisis in others – and better dealt with as such.

A problem I have alluded to so far and not taken up is the legal issue – represented in the UK by the Mental Health Act.

Slide: Diagnosis, loss or liberty and compulsory treatment

The gain for human rights in connection with mental health during the 20th Century, shown in the top half of the table, appears to being reversed in England in the 21st Century represented by changes in the Mental Health Act in 2007. If we are to make progress in tackling race and culture issues surely we have to stop this trend. To say that this is a political issue is not an option; psychiatry and psychology have always been partly political. Right from the start, both disciplines have been involved in social control systems – or controlling individuals - one way or the other. This talk is too short to pursue this subject further – perhaps another time and place.

I would now like to summarize the sorts of changes we should be aiming at in order to meet the challenges of race and culture issues. I shall do this with four slides putting together much of what I have written about especially in the last chapter of my book *Mental Health, Race and Culture* third edition called 'mental health for all'. I shall go through these slides quickly suggesting you read them at leisure later on and may be read the book chapter and read around the topics that interest you.

Slide: Mental Health for all 1

First a shift in diagnostic system and re-defining illness models within certain cultural and ethical constraints. Psychiatry needs after nearly 200 years to modernize and in Freudian terms overthrow the traditional father – Kraepelin. Western psychology too needs to move into the modern world I reckon – a start would be an amalgamation of enlightenment-orientated ('religious) traditions of the East with the precision clarity and so on that 19th century western scientific thinking has given us.

Slide: Mental Health for all 2

Then we need I think to make definite changes in the way assessments are made. Sensitivity to the real world perhaps – addressing the social realities which vary from place to place and across cultures. 'Paranoia' for instance could be a way of coping – it depends on the context, the world a person lives in. There is much work in sociology that we could draw on instead of just 'diagnosing' individual pathology. And then I have already mentioned issues around schizophrenia and depression.

Slide: Mental Health for all 3

In making decisions on treatment, we should shift our focus on to social networks of support, coping strategies that promote people's inherent resilience and so expand the types of therapeutic interventions available, drawing from a variety of cultures. Most medications should be seen as adjuncts to coping - helping people to cope - and not (as too often still justified without any evidence for such a view) still thought of as a cure for an illness. In other words I am not advocating getting rid of all medication, just using medication for supporting people rather than destroying them – away from the model of 'attacking' illnesses, as if they are like infections.

Slide: Mental Health for all 4

Finally, systems of care need to be re-structured with changes in the legal system being essential; risk-assessments must be separated from 'illness'; cultural understanding central to assessments; and care must be therapy-driven care. We need to take on board that evidence from international studies suggests that user-choice in a context of a plurality of available therapies gives the best outcome. The Care and Partnership (CAPA) approach in organizing services, pioneered in Hertfordshire, is worth looking at in this respect.

The last three slides are merely headings and each needs careful study and elaboration. Perhaps I shall get a chance to do this with some of you to some extent in the discussions after this event or another time. But you are welcome to correspond on any of these issues via my website.

MASTER CLASSES IN MENTAL HEALTH, RACE AND CULTURE 2011
Wednesdays 5.30 - 7.00 PM 5 & 19 October, 2, 16 & 30 November and 14 December

END