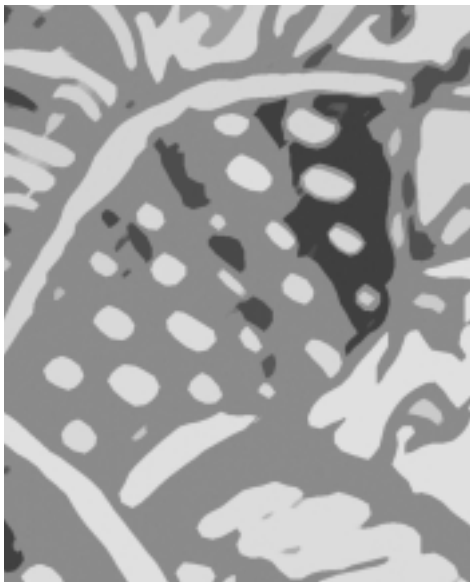
Suman Fernando on cultural diversity in NHS therapies

Backing user choice

In the 1960s and 1970s, the World Health Organisation (WHO) carried out a large research project called the 'International Pilot Study of Schizophrenia'. They collected 'cohorts' of people who adhered to the Western diagnosis of 'schizophrenia' attending hospital centres in seven locations in both industrially 'under-developed' and 'developed' (Western) nations. The aim of the study was to see how well or badly 'schizophrenics' (sic) did medically in different cultural settings. Of course, we now know that schizophrenia is merely a category constructed in a Western cultural setting of the early twentieth century, and so one that may not have much meaning in other cultures. But when this research was started, the WHO did not question the validity of the concept of schizophrenia as a biological illness. What the WHO found was that people given a schizophrenia diagnosis in under-developed countries did much better when compared to those in the developed world; the former having a much higher level of 'recovery' – a better 'outcome', in medical terms.



This result was confusing to biologically minded psychiatrists and even others, because the places where 'schizophrenics' did better were the very places that were deficient in Western-style mental health services, affordable drugs, rehabilitation centres and so on. Many of these places had very few social workers and hardly any community psychiatric nurses. The establishment found it difficult to stomach a conclusion that the lack of (Western-style) treatment, follow-up and rehabilitation correlated with a better outcome.

In the 1980s, a variety of theories emerged in the psychiatric and social science literature as to why (in medical terminology) 'schizophrenia' had a better prognosis in under-developed countries compared to the West. Some claimed that the WHO researchers did not allow for urban – rural differences or that recovery was related to labour markets. Others believed that it was all concerned with labelling: that 'schizophrenics' were accepted in traditional Asian and African communities and so their 'illnesses' did not last so long. Still others (like me!) thought that the whole thing had been a waste of money – like had not been compared with like because the category 'schizophrenia' may not conform to 'illness' in some cultural settings.

Recently, an anthropologist-researcher from New York[1] has produced an ingenious and plausible reason for the original WHO findings. The researcher interviewed and followed up people from Kerala (South India) with mental health problems who had been treated with (a) Ayurvedic (indigenous Indian) medicine, (b) allopathic (Western) psychiatry and (c) religious healing (at a Hindu temple, Muslim mosque and Christian church). The people he interviewed and their relatives had a diversity of experiences of all three systems. Some benefited from one type of treatment but not from another. Many had tried out one and then switched to another. What 'worked' for one person did not necessarily work for another, but they all worked to a greater or lesser extent.

The insight gained from these new findings seems to throw light on the findings of the earlier WHO study. It is well known that people in under-developed countries have access to many types of mental health therapies – something that is not quite so evident in the developed world, where traditional Western psychiatry dominates. The restriction to access is, of course, money, since all except the Western therapies are usually costly. It is at the very places where therapeutic pluralism is available that the WHO found a 'better outcome' for 'schizophrenia'. So the likelihood is that what resulted in this 'better outcome' was the pluralism in therapies that allowed people to 'find a fit' suitable for each one. In other words, the research in South India argues for pluralism, with user choice as the best system for mental health services.

There is a lesson for us here in Britain. Government policies tend to emphasise the need for uniformity of services across the country, implying that for any given 'condition' the same therapy works for anyone. True, mental health trusts are supposed to gear the 'therapy package' to need – each

according to his or her need. But isn't it time we thought of changing this motto to read 'for each according to his or her choice'? At any rate, we need to diversify the forms of therapy that the NHS provides, especially in terms of the cultural origins of the therapies.

The question for us in Britain is the feasibility of statutory services providing a cultural mix of therapies. A major obstacle lies in the assumptions and viewpoints inherent in the disciplines that underpin the services, especially Western psychology and psychiatry. One alternative is to think up the minimum changes that are needed in the 'culture' of disciplines that inform mental health services in order to open up these disciplines to a variety of cultural influences. I believe that a multicultural mental health system can then emerge, where service users are legitimately presented with a variety of (what are seen as) 'therapies' drawn from a diversity of cultural backgrounds. Then, user choice can be a reality that is backed by the service culture. I think this scenario is quite feasible, and I shall now refer briefly to just one or two of the changes required to move forward on these lines that I have explored at greater length in my recent book.[2]

In my view, holistic thinking linked to the recognition of a spiritual dimension to human existence and experience should be specifically incorporated into every individual psychiatric assessment that is made. Holistic thinking promotes a feeling of connectedness to other people and things (the 'I and I' principle of the Rastafarians, for example), to the 'community' (a 'community spirit') or, even wider, to the land or environment (an 'ecological' spirit), the earth and the sky, and the cosmos (unity with 'atman', the Hindu godhead or the Christian God, for example). Spirituality is emphasised in Asian and African traditions, but sadly became lost in the West during what Erich Fromm called the 'big plunge into objectivity'[3] that occurred in the nineteenth century. The recognition of holistic thinking within psychology and psychiatry would resonate in interpretations made by psychiatrists – for example, in identifying 'psychopathology'. Certain changes should then result. For one thing, (what seems to be) an erroneous attribution of cause (someone being convinced about being persecuted, for example) would not be seen as a symptom of 'illness' with a likely diagnosis of 'delusions' or 'paranoia', but as a way of relating to the world around him or her. Then, many instances of so-called 'paranoia' would be understandable or else appraised as a 'problem' similar to (say) obsessions or a problem of personality or relationships. Incidentally, if such an approach is combined with definitive attempts to recognise and allow for the experience of racism, I believe there would be a significant fall in the identification of 'paranoia' and indeed 'schizophrenia' among black people in Britain.

The approach in current psychiatric practice is to assume that 'mental illness' is basically of biological origin, and so the first line of 'treatment' tends to be medication. The experience of people who take neuroleptics tends to support the idea that these drugs may suppress feelings, irrespective of whether the feelings are 'bad' (for example, uncontrollable anger, hearing 'voices') or 'good' (for example, loving affection, interest in other people). Many people may see the former suppression as beneficial but the latter certainly makes one's life less 'human', to say the least. Psychiatry has to get away from seeing drug therapy as focusing on 'illness' or even symptoms. Then, a pragmatic approach to the use of medication is possible. People who take neuroleptics would become the experts on different drugs. Experiences of service users, rather than double-blind controlled trials based on professional assessments of 'mental state', would become the evidence base for medication. This approach would detach medication from diagnosis and allow a similar pragmatic approach to other therapies.

In Britain, 'talking therapies' are grounded in worldviews and ways of thinking that are specifically Western. This must change. Counsellors and psychotherapists must have grounding in a variety of psychologies from around the world (including Western psychology). Such a change will inevitably come through in practice as a broadening of approach. And 'talking' may then be only one of many modes for non-physical types of therapy. And there will be no need for add-on 'cultural sensitivity' training.

These, then, are a few changes in psychiatric and psychological practice that I believe can be made without too much upheaval. Without making changes at the grassroots – the level of psychiatric and psychological practice – broad policies such as 'Delivering Race Equality' have little chance of improving the quality of services actually experienced by users.

1. Haliburton, M. (2004) 'Finding a fit: Psychiatric pluralism in South India and its implications for WHO studies of mental disorder', *Transcultural Psychiatry*, 41(1): 80–98.
2. Fernando, S. (2003) *Cultural Diversity, Mental Health and Psychiatry: The Struggle against Racism*, Hove and New York: Brunner-Routledge.
3. Fromm, E. (1960) in E. Fromm, D. T. Suzuki and R. de Martino (co-authors) *Zen Buddhism and Psychoanalysis*, London: George Allen and Unwin.