

Class 1 (5 October 2011)

Traditions of mental health and illness; what diversity means

Slide: Racial and Cultural Issues in England

The first slide is taken from my very first book published nearly 25 years ago. I am sure many of you know what is summarized here: 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 a community treatment order; more likely to be deemed both mad and bad and so kept in forensic institutes such as Broadmoor; not referred to or accepted for counseling 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 dominates mental health services. Similar lists have been re-produced during the past fifteen years because the problems have not really changed very much, and now, today, we know much more about the background to the issues. And it is this background that I aim to explore a bit with you today.

As a foreword to my talk I would like to mention, but not go into a discussion on, the way the terms 'race' and 'culture' are used today.

Slide: Race

Race is essentially a social construct where relatively minor (from a biological point of view) minor aspects of physical appearance are used as indicators for largely imagined, but sometimes very fundamental, differences between people. In spite of 'race' being rejected as a useful way of categorizing people, 'race thinking' (thinking of people predominantly in terms of their 'race') this persists and is something we have to contend with.

Slide: Culture in the context of mental health

Culture is no longer seen as a fixed 'thing' about people or societies, but more a changing mixture of behaviours, values, world-views etc. that define our identities, and with which we negotiate our lives.

Something else we need to bear in mind as a backdrop to my talk is the historical context vis-à-vis race and culture within which psychiatry and western psychology developed.

Slide: Historical Context of Psychiatry

An important message in this diagram is that the disciplines of psychiatry and western psychology came about between one hundred and two hundred years ago within (what we call) 'European Culture' which included – and still includes I think - a powerful racist ideology that has had a powerful effect on us all. This is something we will come back to later.

We can note in passing that some aspects of what is included today in western psychiatry can be traced to the early scientific thinking incorporating the illness model for human emotional problems in the Islamic Arab Empire that had its heyday between the tenth and 13th centuries AD.

Slide: History of Melancholia as Illness

I wrote a short article in *Openmind* on this – available with many other articles on my personal website – and we can note for example that Maimonides – a Jewish Rabbi who was the physician to the Caliph and whose statue stands in Cordoba to this day – Maimonides described mania and melancholia as two sides of the same illness (now called bipolar disorder) 900 years before Emil Kraepelin (often called the father of psychiatry) did so at the turn of the 19th to 20th Centuries when he founded the current system for categorizing mental illness.

More recently, cross cultural studies in depression have explored many avenues and the next slide gives you a sort of snapshot of how the individual experience of depression is seen today from a transcultural perspective.

Slide: Cross-cultural variation of depression

There are three main lines to follow. First, one way of seeing depression as illness is that the basic disturbance (as it were) is a failure or loss, experienced according to the emphasis in the culture of ‘self’ or ‘non-self’. Then, loss may be felt as isolation from community or family; a sense of failure towards others as shame; and a sense of failure toward oneself as guilt. Thus in cultures that emphasize the individual rather than family or community, guilt would emerge as a cardinal ‘symptom’ of depression seen as ‘illness’. There is a wider theory that depression only occurs as illness in cultures that ‘psychologize’ experience. Where somatization is the predominant mode, then other types of illness may occur. Finally the most attractive theory 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 West African cultures) depressive affects are tied to issues of existence and so dealt with often in a religious or spiritual mode; this is 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.

I come now to make some general statements about the cultural background to psychiatry and psychology.

Slide: Traditions of Western Psychiatry and Psychology

Western psychology may be called ‘scientific psychology’ or ‘secular psychology’ because it developed in a post (European) Enlightenment context where religion was excluded. But it is only one of many systems of knowledge about ‘mind’. The western brand competes with indigenous ideas about mind that come from other non-western traditions in Asia, Africa, and pre-Columbian America to name a few, although admittedly these non-western systems are mostly allocated to religion - where perhaps they belong anyway. And the reality unfortunately is that what is talked about as ‘psychology’ all over the world is defined in traditional western terms only. When academic institutes teach psychology it is the subject derived from the western tradition that is taught; Buddhist psychology, Hindu psychology,

African psychologies and those from Pre-Columbian American sources are merely topics within religious or cultural studies, seldom recognized as true (*sic*) psychology.

The case of psychiatry is different. In effect, there is only one version of a narrow *medical* specialty concerned with disorder of mind as distinct from body, and that is psychiatry – the system developed in the western tradition, the scientific tradition. What has been called ‘Tibetan Psychiatry’ by free-lance writer and mental health worker Terry Clifford (1984) is very different culturally and, in its practical application, it is basically in the Ayurvedic (Asian medical) tradition together with spirituality.

As psychiatry extended its domain much as colonialism did - and often closely allied to colonialism and imperialism – its development as a practical application now extends all over the world; and it is being elaborated and studied in Asian countries like Japan and increasingly in China and India. Because of this, it is preferable to speak of bio-medical psychiatry, rather than western psychiatry, to distinguish it from what may emerge as an amalgam of western and local systems. Yet, there are still active indigenous non-western traditions – admittedly under-developed and until recently actively suppressed by western powers – active traditions recognizable as culturally different to psychiatry concerning health, including mental health, and ways of thinking about deviations from health – may be as illness, but also as problems of the mind, spiritual experience, possession by spirits, and so on. To some extent, in some places western and non-western are becoming mixed, not least as ‘cults’.

In order to discuss these different approaches to mental health, I shall refer to East and West or western and non-western. Please note that these are rough divisions that represent traditions and not current geographical locations. And more importantly (as I talk also of ‘race’), I do not see these categories as black and white in any sense of the phrase. Clearly, the concept of mind is very much involved with ‘mental’ matters, so what are the different traditions here.

Slide: Culture and ‘Mind’

The proposal in the mid-seventeenth century by René Descartes that mind and body belonged to two ‘independent and separate realms’ (Capra, 1982, p. 45) composed of ‘utterly different substances’ (Koyré, 1954, p. xlv) set the stage for western thinking about mind leading to western psychology. Descartes suggested that the mind – which was initially referred to as soul - should be studied by introspection, and the body by methods of natural science (Capra, 1982; Ryle, 1990). But as western psychology developed in the late eighteenth century, it was influenced by medical studies which analyzed human bodies by looking at smaller and smaller parts of the whole; and also by studies of the nervous system supporting a mechanistic basis for mental activities taking the model from Newtonian mechanics. So to the dualist mode was added a reductionist / mechanistic approach for analyzing mind; and the tools used had to be ‘objective’ and so detached from personal feeling as much as possible. Nowadays these tools are mainly questionnaires and schedules. Meanwhile the separation during the 18th Century of religion from the ‘scientific’ approach meant that ideas of spirituality were excluded.

Mental health is a nebulous concept at the best of times (see Kakar, 1984: 3). How this concept is best interpreted in the provision of mental health services in a multicultural context is complicated. I have chosen to simplify a complex picture by presenting viewpoints from

different traditions. In doing so I am mindful of the danger of stereotyping and that similarities (between cultural traditions) should never be under-estimated. Also I acknowledge the danger of attributing to 'culture' what could be political, racist or misogynist attitudes that people within the cultural tradition are struggling against. Notwithstanding these problems, I do not see any other way of exploring cultural diversity except by comparisons between 'western' and 'eastern' or 'western' and 'non-western', emphasizing that, today, the categories mostly refer to traditions - and may be states of mind - rather than geographical regions (Kakar, 1984). I take a lot from the published work of Sudhir Kakar, Indian psychoanalyst and writer, especially his early book: *Shamans, Mystics and Doctors* (Kakar, 1984).

Slide: Ideals of Mental Health

In simple short hand, eastern traditions see health as a harmonious balance between various forces in the person and the social context while western traditions see health as individualized sense of well-being or even happiness which could be transitory. So, the Chinese way of thinking sees all illness as an imbalance of *yin* and *yang* (two complementary poles of life energy), to be corrected by attempts to re-establish 'balance' (Aakster, 1986); the Indian tradition emphasizes the harmony between the person and their group as indicative of health (Kakar, 1984); and the concept of health in African culture is more social than biological (Lambo, 1969).

The dominant theme in western culture, reflected in psychiatry and western psychology, is that problems identified (by the person concerned or by a 'specialist') as being concerned with thinking, emotional reaction, feelings, fears, anxieties, depressions etc. are conceptualized in terms of illness dealt with - 'treated' - with a variety of interventions aimed at 'cure' or alleviation of 'symptoms. Even family interactions and social behaviour (as in 'psychopathy'), and hatred and jealousy (as in 'pathological jealousy') are sometimes fitted into the illness model. Clearly, this western way of conceptualizing such a wide range of human problems is alien to Asian and African cultural worldviews although admittedly a much narrower range of problems, nearly always identified by bodily changes, are seen as illness; but even then, these 'illnesses' are conceptualized as disharmonies within a total (holistic) self. In short, balance and harmony, both within oneself and within the family or community, are important aspects of eastern thinking about mental health while, in the West, self-sufficiency, efficiency and individual autonomy is the overall model of a mentally healthy life. In this latter mode of thinking, problems are clear-cut, each being separate from another, so that 'closure' of each one in turn may be sought. In an eastern way of thinking problems are there but no specific answers - one explores problems in order to understand (and perhaps accept them) not looking for specific answers. So problems-solving or closure (of problems) is not so important.

Anyone trained within western schools of thought (for example in the disciplines of psychiatry and western psychology and many systems of counseling and psychotherapy) will be taught to see self-sufficiency, personal autonomy, efficiency and self-esteem as the correct basis for discussions about mental health - and this applies to people from various backgrounds - although trainees from 'other cultures' may become aware of some cultural dissonance between training and their own thinking. This (sometimes unwitting) credence given to western ideas - a sort of cultural arrogance - is very close to, if not identical with, institutional racism.

The importance of understanding the variety of 'ideals' (as above) for anyone involved in service provision, centres on how this understanding can be applied in practice. In my view, the 'ideals' I have noted are seldom if ever held by any one person or cultural group in an uncontaminated form. As with all cultural forms, the concept of ideal 'mental health' is 'hybrid' or a mixture of elements from these ideals. So in practical terms, what is required is to make out what sort of mixture is the reality in the case of each person or group. This may be the main expertise necessary for professional practice in a multicultural setting. Clearly then the aim of service provision is to provide means for this particular ideal to be realized.

Current mental health systems in the statutory sector are usually dominated by a model of identifying at best 'mental health problems', and at worst pure biological 'illness', and then devising interventions or 'treatment' usually highly individualized. In non-western cultural traditions, many of the problems seen as illness or matters of mind *per se*, may be seen as spiritual experiences or ethical dilemmas or issues of community life and so on. And more generally, coping with them at an individual level (whether they are seen as illness or not) is more a matter of 'liberation' – being free of them - rather than control.

Slide: Liberation / Therapy

The western approach to therapy or liberation focuses on control, or understanding by analysis usually via a reductionist approach (in for instance psychotherapy). In the eastern approach, greater emphasis is given to acceptance (may be toleration based on resilience) of the problems or symptoms (rather their control), and understanding (in an eastern sense) is by contemplation or an interchange of feelings rather than intellectual analysis of feelings.

And so we come to 'race' or rather issues of racism.

Although some of us like to imagine that with the election of a black president as leader of the so-called 'western world', we are now in a post-race era, the reality at least in the world of mental health is very different. So let's look at what we have inherited and how our inheritance – where we come from, where psychiatry and western psychology come from – how our traditions affect how we go about our business in practice. First consider very briefly the construction of what we call 'schizophrenia' because this diagnosis represents to many people what madness means, and the idea of 'schizophrenia' as a medical illness is deeply implicated in the oppressive nature of psychiatry.

Slide: Concept of schizophrenia

The first point to note is that this diagnosis came into use at the turn of the 19th to 20th centuries but is far from being validated scientifically as representing a biological illness, in spite of massive amounts of expenditure on researching its associations. It is basically a deeply flawed concept to use in a multicultural setting. There have recently been calls for its abolition, although that is not simple because of its links with social and political systems, apart even of psychiatry (Fernando, 2003: pp. 179-181). I do not have the time to go into all this here. I refer you to chapters in the book I co-authored with Ndegwa and Wilson called *Forensic Psychiatry, Race and Culture* published in 1998 for detailed discussion of how racism (that eventually led to the Nazi movement) was associated in the construction of schizophrenia in the early 20th Century, and to a more recent *Cultural Diversity, Mental Health and Psychiatry* (Fernando, 2003) and *Mental Health Race and Culture* (Fernando,

2010) for discussion on issues around the diagnosis. I would like to get on now to discussing racism in psychiatry and western psychology more generally.

Slide: Racism in the 19th Century

In the mid-eighteenth century, Rousseau's concept of the 'Noble Savage' proposed that people who lacked the civilizing influence of western culture were free of mental disorder. Later, in the 18th and 19th centuries when arguments arose (as they still do) as to whether black people suffer more insanity than do white people, eminent psychiatrists supported the Noble Savage view claiming that insanity was rare among Africans, Native Americans and others who were in a 'savage' state. But by then, another stance was evident too (Lewis, 1965), namely that non-Europeans were mentally degenerate because they lacked 'culture' and so they were incapable of showing 'mental illness' anyway. A third viewpoint voiced by American psychiatrists in the 19th Century, quoting statistics of admission to asylums in different parts of the USA, was this: Black Americans were relatively free of mental illness when in slavery (in the South) but subject to mental illness once set free (in the North). Various illnesses were linked to this theory. Drapetomania or the illness of running away was one and some psychiatrists supported slavery for black people as being conducive to their mental health almost into the twentieth century.

On this side of the pond, John Langdon Down (1866) claimed that the cause of what was then called 'idiocy' – the so-called illness when people had severe learning difficulties – the cause was racial throwback, white people reverting to a primitive ('black') mentality. Dr Down had apparently found that people with this diagnosis in asylums in London had physical characteristics of Malays, Ethiopians, Natives of America and Mongolians – most he said were 'Mongols' (hence the name that stuck for many years). The first psychiatric text book to document mental illness of non-Europeans was one on adolescence by Stanley Hall (founder of the American Journal of Psychology). There was a whole chapter on what Stanley Hall called 'adolescent races' referring to (adult) Indians, Africans and Native North Americans as showing the characteristics of immature white children – i.e. being psychologically under-developed. That idea too held for many years and still reverberates (as we shall see). These are just examples of how deeply racist thinking was embedded in psychiatry and psychology as it developed - and the story continues

Slide: Racist discourse in modern times

In the early part of the 20th Century, Kraepelin, German professor and the so-called father of psychiatry, postulated that Javanese, and by extension all Asians, did not suffer depression because they were psychologically under-developed - 'akin' (as he put it) to immature European youth. This idea continued throughout the first part of the 20th Century with numerous observations in Africa where the apparent lack of depression as illness was attributed to the lack of a 'sense of responsibility' and (by Carothers – who was accepted by WHO as an authority on African psychiatry) to Africans having minds that were like those of 'leucotomized Europeans'. In the seventies as Social Psychiatry became a research interest, Julian Leff (1973, 1977), analyzing cross-cultural findings using traditional psychiatric research methods, Leff concluded that Asians, Africans and African-Americans had under-developed emotional differentiation compared to Europeans – white people.

I am sure you know about the racist IQ movement but perhaps Jung's theories on 'race' are less well known. Carl Jung fancied himself as a specialist on black people, having visited

Africa and India. I shall not go into what he said about Indians but after going to the US, he postulated his 'racial infection' theory. This was that white Americans, although belonging to the same racial stock as Europeans, had become deviant as a result of their psyches being 'pulled down' to primitive levels by living too close to black people. I could go on but the problem sometimes in specifying racism in current thinking in psychology and psychiatry is that its expression is now quite subtle and often covered over by cultural, and other seemingly innocuous, language – something that is happening in other spheres of life too I reckon. For example, one finds ways of expressing distress being dismissed as anomalies or certain cultural interpretations of problems as unrealistic – statements which when examined closely turn out to be underpinned by racist assumptions about people or their cultures. The cultural arrogance which I referred to in talking about assumptions in psychiatry and western psychology are quite often implicitly racist.

I am nearly at the end of my talk today. People working in mental health are often asked to be culturally sensitive. I hope this talk has given you some notion of why this is so difficult and often not implemented. The final slide of this master class summarizes why this is so and the lesson that cultural sensitivity on its own would be useless without some way of being anti-racist too.

Slide: Problems of being culturally sensitive

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