

The Effect of Western Psychiatric Models of Mental Illness on a Non – Western Culture

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Abstract

The treatment of mental illness historically has been always based on western nation's mode of thinking. That's could be understandably well because western mode of medical treatment has always dominated the world despite surge in alternative medicine in recent times. Medicine and treatment in mental illness are dealt by personnel who are trained in western medicine, and therefore, their orientations are western based. These trained personnel faces challenges when they are diagnosing mental illness across different cultures that are found

not only around the globe but also within the western domain given the migration pattern in the last half a century or so. Through the analysis of the various literature on this area and the practices therein, the articles examines the social process of the restrictive medical model that dominates western thinking of mental illness creates a vacuum in dealing with patients from cross culture largely due to their own views of what constitutes mental illness. A patient's deviant behaviour may be the result of an upbringing which are regarded as unusual to western norms of living. Specialist in the field of psychiatry being western in their outlook and mostly educated in that aspect will apply therapies that are alien to non-western patients who may believe that they are possessed by spirits which explains their deviant behaviour. The authors argue that the conflict faced by psychiatrist and related professionals can be resolved by a better understanding and adopting a universal approach in treating mental patients of different culture. The question is whether they are willing to confront ethical issues that can be intrinsically challenging especially when they are controversial.

Keywords: psychiatry, mental illness, cross-culture

1. Introduction

Medicine in psychiatry and mental illness are deeply intertwined and the persons dealing with the mentally ill are typically medically trained professionals (Goldberg & Huxley, 2001). Major conceptions of the causes, courses and cures of mental illness are fundamentally derived from medical terms originally used to describe physical illness. Society currently uses the model of physical illness as a basis for the terms and concepts to be applied to deviant behaviour. Such behaviour is termed pathological and is classified on the basis of symptoms and diagnosed accordingly. The process of analysis is based on the western concept which dominates the medical model in the treatment of mental illness. Processes designed to change behaviour are called therapies and are applied to patients in mental hospitals. If the deviant behaviour ceases, the patient is described as cured (Bryant, 2011).

The medical model argues that aberrant patterns of affect, thought and behaviour are best viewed as symptoms produced by an underlying pathological condition. This model asserts that diseases maybe caused by physio-biological factors that may involve genetic, metabolic, biochemical, or other organic pathology (Melvin, 1981). Mental illness is like any other illness and is unique only in that, symptoms are not fevers and aches, but unusual patterns of behaviour. The causes of the illness may be any number of psychosocial factors ranging from unusual patterns of upbringing and socialisation to intense and stressful life experiences.

2. Western Medicine and Traditional Views

Throughout the history of western medicine, with a few exceptions, western – trained psychiatrist have viewed traditional medical systems and beliefs from the vantage point of western medical science regarding them as not only primitive but archaic. They also view this as not related to scientific medicine as well as the health of human populations as whole. The emphasis has been on quaint but queer, customs and “love of the “savage”.

The success of positivistically – based science as measured by technological achievement has resulted in the perception that western scientific development as the legitimate interpreter of

nature. Phenomena which do not fit prevailing scientific paradigms are often rejected as unscientific or not logical. Thus, western – trained psychiatrists, who have encountered unfamiliar, and sometimes bizarre, syndromes of psychological disturbance in parts of the non – western world, have tried to understand these syndromes in terms of their western categories of mental illness, for example, “schizophrenia” or “manic depressive psychosis”.

Definition of abnormality and normality vary throughout the world, and mental health which are based upon the measurement of certain physiological and other variables, are also based on what society considers to be normal or abnormal (Lake, 2012). Therefore it could be argued that the western medical model of mental illness is not necessarily applicable to non – western cultures. Social definitions of mental illness are based on shared beliefs within a cultural group as to what constitutes the ideal “proper” way for individuals to conduct their lives in relation to others. These beliefs provide a series of guidelines on how to be culturally normal (Normality takes into account on individual’s dress, posture, facial expression, voice among others).

Displays of behaviour that are abnormal by the standards of everyday life, must be seen against the background of the culture in which they appear. These behaviours are controlled by implicit cultural norms, which determine how and when they appear. In many non – western cultures individuals experiencing feelings of unhappiness, guilt, anger or helplessness, are able to express these feelings in a standardised language of distress. This may be purely verbal or involve extreme changes in dress, behaviour, or posture.

To the western trained observer, some of these languages of distress may closely resemble the diagnostic entities of the western psychiatric model. For example they may involve statements such as “I’ve been bewitched”, “I’ve been possessed by a spirit”. In a western setting, people making this type of statement are likely to be diagnosed as psychotic or schizophrenic (Mezzich, 2002).

3. Mental Health and Spiritual Possession

In certain parts of the non- western world, patients freely admit to being possessed by supernatural forces as an explanation to their psychiatrist abnormalities. This is not considered as being abnormal or a pathognomonic of mental illness in their society. One example of this is the widespread belief in Africa of spirit possession as a cause of mental or physical ill health. In these societies as Lewis (1971) notes “*possession is a normative experience.....whether or not people are actually in trance, they are only possessed when they consider they are, and when their members of their society endorse this claim*”. Possession, then, is an abnormal form of behaviour, but are in conformity with cultural values, and the expressions of which are closely controlled by cultural norms.

Another form of controlled abnormal behaviour is glossolalia- “speaking in unknown tongues”. The cause of this is believed to be the result of a supernatural power entering into the individual, with control of the organs of Speech by the Holy Spirit who prays through the speaker in a heavenly language. It is dissociative, trance- like state, in which the participants tend to have their eyes closed, make twitching movements and fall, they flush, sweat and may

tear their clothes. This is a feature of religious practices in segment of societies in India, the Caribbean Islands, Africa as well as many Pentecostal churches in many western countries. These behaviours can be seen as a form of controlled abnormality which to an eye of a western – trained psychiatrist as an evidence of mental illness that needs to be diagnosed and treated accordingly across cultures.

4. The Sociology and Culture of Mental Illness

The biological approach to mental illness sees the diagnostic categories of the western psychiatric model as being universally applicable, since they have a biological basis. However from a social labelling approach, Waxler (1977) argues that mental illness definition changes depending on the society and therefore cannot be said to have a universal existence. She notes that, in western societies, social withdrawal, lack of energy and feelings of sadness are commonly labelled as “depression” and needed to be attended to on a serious basis. In Sri Lanka the same phenomena receives less attention and therefore the patients receives very little treatment. The definition of mental illness is thus culture – specific. The process of labelling involves a first stage where an individual deviant behaviour is labelled as “mental illness”. Since it only exists by virtue of the society that defines it as “mental illness”, it is therefore a relative concept and cannot be easily compared among different societies.

However this perspective is inadequate as it neglects the biological aspect of mental illness, especially in those conditions where there is a definite feature (such as brain tumours or dementias).

It has been argued that there are some universalism in abnormal behaviour. While there is wide variation in their form and distribution and the western categories of major psychoses, such as schizophrenia are found throughout the world, though they may be given different labels in different cultures. Those who suffer these extreme psychological disorder are usually perceived by their own cultures as exhibiting “uncontrolled abnormal” forms of social behaviour (Selim, 2010). To a variable extent their clinical pictures can be compared among societies.

Foster and Anderson (1978) have suggested that this comparison should be between their symptom patterns rather than between diagnostic categories; on this basis the problem of trying to fit other cultures’ mental illness into western diagnostic categories can be overcome. Indeed, in recent years a number of studies have indicated difficulties in standardising psychiatric diagnoses between different cultures. Reasons for this include lack of concrete hard physiological data, the vagueness of diagnostic categories. In addition the inadequate range of explanatory models available, the subjective aspect in diagnosis, and the influence of social, cultural and political forces on the process of diagnosis.

Unlike the diagnosis of medical diseases there are often little evidence of typical biological malfunctioning. Host psychiatric diagnosis is based on the doctors’ subjective evaluation of the patients, dress, speech and behaviour as well as their performances in certain standardised tests. The aim is to accommodate their symptoms and signs into a recognised category of mental illness. However according to Kendell (1975), the majority of patients encountered by

trainee psychiatrists do not possess the typical cluster of symptoms of a particular condition. As a result trainee psychiatrists learn how to assign diagnoses largely by the example of their teachers and what their teachers regards as, say schizophrenic for example. Therefore diagnostic concepts are not securely anchored. They are at the mercy of the personal views of influential teachers of therapeutic fashions.

5. Mental Health, Morality and the State

Political and moral considerations also play a part in the choice of diagnosis and they may be called upon to decide whether a particular form of socially deviant behaviour is “mad” or “bad”. Psychiatrists making these decisions, are likely to be under the influence of social and political forces, the opinions of their colleagues and their own moral viewpoints. In their study of mental illness among immigrants to Britain, Littlewood and Lipsedge (1982) suggest that psychiatry can sometimes be used as a form of social control. Misinterpreting the religious and other behaviour of some West Indian patients, as well as their response to discrimination as evidence of schizophrenia. By contrast with the high rate of schizophrenia among West Indians, in Britain, depression is rarely diagnosed. The authors suggest that whatever the empirical justification, this frequent diagnosis in black patients of schizophrenia (bizarre, irrational, outside) and the infrequent diagnosis of depression (acceptable, understandable, inside) validates our stereotypes. In dealing with immigrants and the poor, they warn against psychiatry’s role in camouflaging disadvantage as a disease.

Another problem frequently encountered in making psychiatric diagnosis cross – culturally is that of somatisation, the cultural patterning of psychological disorders into a language of distress of mainly physical symptoms and signs (Philip Messent, 1992). This has been reported from many cultures especially from the Far East. It is particularly a feature of the clinical presentation of depression. These depressed patients often complain of variety of diffuse and often changeable physical symptoms namely, lassitude, headaches, weight loss, dizziness etc. They frequently deny feeling depressed or having personal problems. Klineman (1980) claims that in some groups or cultures somatisation represents a culturally – specific way of coping with these affects and functions to reduce or entirely block introspection as well as direct expression.

Rubel (1977) argues that there are a group of these illness which are peculiar to a particular culture. Each of these culture– bound disorders is a specific cluster of symptoms, signs or behavioural changes recognised by members of those cultural groups and responded to in a standardised way. They usually have a range of symbolic meanings for both the victim and for those around him (Christine S. Wolf, 1985). They often link an individual case of illness with wider concerns including his relationship with his community. In many cases they play an important role in expressing and resolving both anti-social emotions and social conflicts in a culturally patterned way. Among the few that have been described are: amok, a spree of sudden violent attacks on people, animals and inanimate objects, which afflicts females in Malaysia.

In addition to these specific syndromes, a more diffuse cultural patterning determines the language of distress in which certain types of psychological disorder are expressed. In these

cases, the mode of presentation is cultural-bound, though not the exact pattern of symptomatology.

In the western world most of the focus of psychiatry and psychology are on the individual patient. Most of his diagnosis and treatment takes place in specialised settings such as a doctor's office, far removed from his family and friends. In the non-western world, particularly in rural or small-scale society's illness whether somatic or psychological as well as its treatment, is considered to be a social event, which intimately involves the patient's family, friends and community. In many cases, ill-health is interpreted as indicating conflicts or tensions in the social fabric. Klineman (1980) uses the term cultural healing, when healing rituals attempts to repair these social tears, and reasserts threatened values and arbitrate social tensions. Healing takes place at many levels: not only in the patient restored to health but so is the community in which he lives. The aim of treatment, therefore, is to resolve the conflicts causing his illness, restore group cohesion, and integrate him back into normal society.

6. The Community and Mental Illness

Unlike the western world, psychological disorders are seen as useful to the community. For example, Wander (1977) notes that in small-scale societies mental illness are useful, even necessary. It incurs obligations between people (such as the obligation of family, friends and neighbours to attend and pay for a public healing ritual), strengthening the ties within and among groups. It is apparent that there are complexities in making psychiatric diagnoses and especially in defining "normality" and "abnormality" in members of other cultures. In making cross-cultural diagnosis, the health care practitioner should be aware that cultural factors does have an influence in fairly large areas of the diagnostic categories and methods of western psychiatry. The role of the patient's culture in helping him understand and communicate his psychological distress, how the patient's belief and behaviour are viewed by other members of his cultural group. Whether the abnormality may regarded as helpful to the particular cultural group or not is subjective. The specific symptoms, signs and a remarkable change in his behaviour seen in the patient are interpreted by him and by his community, as evidence of culture-bound psychological disorder.

7. Conclusion

In view of the complexity involved in diagnosing mental illness across cultures, is in large part attributed to the restrictive medical model that dominates western thinking about mental illness. It is imperative that psychiatrists should focus on symptoms patterns across cultures instead of trying to diagnose other culture's mental illness terms of their own view of what constitutes mental illness. Until psychiatrists and indeed other mental health professionals, adopt a truly universal approach in treating those with psychological problems, the present medical model will not be useful in treating patients from non-western cultures.

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