

EXPLANATORY MODELS FOR MENTAL ILLNESS: LIMITATIONS AND DANGERS IN A GLOBAL CONTEXT

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ABSTRACT

This paper outlines a critique of Western biomedical theories of what is called mental illness, and presents an alternative way of responding to mental health problems in people from non-Western cultures. The critique, based on what has been called 'postpsychiatry', problematizes some of the key assumptions that underpin the theory and practice of psychiatry, particularly the problem of how it is possible for us to talk about our inner worlds, and that of causal determinism in psychiatry. Postpsychiatry is also acutely aware of the power relationships that exist between Western and non-Western understandings of distress, and sees these in terms of a contrast between global and local knowledge. In response to the critique, we describe the role of community development in the work of a project called Sharing Voices Bradford, as a way of engaging ethically and sustainably with local understandings in Bradford's non-Western communities.

Until 30 years or so ago, the biopsychosocial (BPS) model dominated most psychiatrists' understandings of mental health problems. (The expression 'mental health problems' is used throughout this article, but this should not be taken to imply that the concept is a universal, applicable to all cultures and at all times.) The model holds that mental health problems arise from an interaction between biological vulnerability (nature) and environmental influences (nurture). In the last quarter of the twentieth century the popularity of this model declined with the rise of what has been called neo-Kraepelinism,^{1,2} the belief that conditions like schizophrenia reflect naturally occurring phenomena that can best be studied through the scientific method. This view has become extremely influential. Its influence can be seen in the World Health Organisation's report on Disparities on Mental Health Care across the World,³ which confidently asserts that mental disorders 'have a physical basis in the brain'. Nevertheless, the influence of the BPS model is still present in the WHO report, which claims that the fundamental ingredients of care are medication, psychotherapy and psychosocial rehabilitation, all of which are key elements of the biopsychosocial model. In this paper we consider the

limitations of these models. This is important because of the trend to present them as a universal way of accounting for emotional distress. The problems we outline here concern how we may talk about our emotional worlds, the nature of causality and its relationship to human experience, and finally the implications of the global dominance of this model, which potentially leaves little space for local understandings of distress. The philosophical underpinnings of our critique are presented elsewhere.^{4,5}

TALKING ABOUT OUR FEELINGS

A central feature of psychiatry is its claim to objectivity. Psychiatrists are trained to adopt a position of neutrality and detachment from the distress they observe in order to describe and measure it. In part, this arises from the way in which 20th century psychiatry interpreted and used the work of Karl Jaspers (1883-1969), the German psychiatrist and philosopher. Jaspers (1963)⁶ regarded phenomenology as a tool for the scientific description and examination of psychiatric symptoms. He separated this from the search for 'meaningful connections' which

was about understanding backgrounds. Jaspers wanted a psychiatry that consisted of both elements but his separation of description from understanding has led to many problems. This separation resonates with a distinction Jaspers also made between the form of a symptom and its content. The former were said to be universal and the object of study of psychiatric phenomenology. The latter was determined by context and open to interpretation. Psychiatry has used Jaspers' approach to phenomenology and claimed that through this it achieves a level of objectivity, justifying its claim to scientific status. At the same time it has neglected the issue of interpretation and relegated questions to do with meanings and contexts to secondary status. We believe that this has led to a situation where the experiences of psychiatric patients are studied in isolation of the background contexts. This means that the initial psychiatric assessment systematically disregards the patient's culture. Psychiatrists have invested great effort and time in the construction of standardized interviews and rating scales to describe and measure patients' experiences in this way. Although much of this has been for research purposes, it has influenced clinical practice.

However, there is a problem with scientific attempts to describe and measure human experience. Put simply, psychological facts are not 'things' that can be talked about in the same way as facts in the physical world. Consider the two sentences:

Water is in the jug.
Sadness is in my heart.

They are very similar. They are both declarative. Their structure is identical. But there is a profound difference between them. We can see the jug and the water it contains. We can describe the water, whether it is clear or dirty. We can measure its volume, and analyze precisely its chemical constitution. We cannot do the same with sadness. To describe sadness we must rely on metaphor and pretend that our hearts are vessels like jugs that can contain sadness. Nobody really believes that sadness is a physical thing contained within our hearts, so it is not possible to measure sadness in the same way we can measure water in a jug. The problem arises because we assume that we can talk about our emotional worlds, our beliefs, values and experiences, in the same way that we talk about physical things. This insight comes from the later philosophy of the philosopher Ludwig Wittgenstein (1967), who has shown the problematic status of these assumptions.⁷ His ideas have helped us to understand the difficulties that arise if we assume that we can talk about our emotions and beliefs as though they were socially available 'facts'.

If this is so how do we know what sadness is? We recognise sadness because it is the very nature of human experience grounded in our common sense understanding of what it is to be human, to be able to identify the emotion and the human contexts in which it occurs. We do this through telling and sharing stories with each other about our hopes, aspirations, struggles and failures. We also rely on metaphor and other figurative uses of language whose meaning is given to us through the particular culture we share, to communicate our feelings and emotions with those around us. In other words we rely on what philosophers call a common-sense interpretive competence to recognise emotional states like sadness or joy. We are mistaken to believe that as psychiatrists and mental health professionals we need special ways to define and describe it, let alone measure it.

PROBLEMS OF CAUSALITY

There is a further problem with the scientific method in psychiatry. Doctors are educated to believe that the only legitimate forms of explanation are causal ones. This is particularly so in psychiatry.⁸ Causal determinism, the idea that the phenomena we observe have antecedent causes that can be explained through scientific laws, is a key element of positivism, the belief that it is possible to investigate human experience and human problems using the methods of investigation from the natural sciences. Both positivism and causal determinism are useful in general medicine where understanding the molecular substrate of disease processes may bring great benefits, but their value in psychiatry is much less clear. With the exception of organic brain syndromes, there is no convincing empirical evidence that psychiatric disorders have a biological basis. In Britain, positivistic research in social psychiatry has shown that poverty, area of residence, and ethnicity are strongly related to compulsory admission rates to psychiatric hospital. Although it is important to know this at one level, such knowledge says nothing of what it is like to be an unemployed Black or Asian man or woman in England, whose daily life experience may be one of racial abuse and social exclusion. The biopsychosocial model invokes 'stress' as a mediating variable between social adversity and mental illness. The purpose of this is unclear. If it is an inherent property of certain social situations then it is redundant. On the other hand, if it is related to the meaning of the context in which the individual is situated, then we should really be attending to these meanings. Human subjects and human experience are too complex for methods of inquiry, such as positivism, that befit the natural sciences

There is a further problem. In psychiatry, causal determinism can be seen in the belief that disordered brain function causes the experiences of depression or schizophrenia. The difficulty is that the correlation of an abnormal mental state with disordered brain function is simply not warranted. Changes in brain function may be a product rather than a cause of the mental state. Correlations represent associations, not causation. Ingleby argues that the neurobiological correlate of depression or psychosis, and the associated mental state may be understood in terms of other factors, such as the person's life story, and the enmeshment of narrative and biology in an endless variety of contexts, social, historical, political and cultural.⁸ Human contexts do not provide causes for human action but grounds or reasons for action. Scientific methods are useful to establish how things happen, but not why they happen. For this we must turn to understanding and interpretation, or that branch of philosophy called hermeneutics. We argue that this approach should be central to our approach to distress and psychosis. Hermeneutics draws attention to the importance of meaning in psychosis⁹⁻¹¹ and trauma.¹² We believe that Jaspers' separation of description from issues to do with interpretation has had a negative effect on psychiatry leading to misguided attempts to fit the complexity of human reality into narrow causal models and frameworks.

LOCAL OR GLOBAL KNOWLEDGE?

The third issue we want to raise concerns what has been called the power of psychiatry,¹² and especially its relationship to what might be called local understandings of emotional distress. Critical thought in philosophy and sociology has drawn attention to the enormous influence that psychiatry and psychology have had in the West. This influence extends way beyond the walls of the clinic, and shapes the way we all think about and understand ourselves. Drawing on the ideas of the French philosopher Michel Foucault, Miller has described the power of psychiatry in terms of the possibilities it creates for us to understand ourselves.¹³ For example, we no longer think of ourselves as being sad or demoralized, but as being depressed, and thus in need of treatment with drugs or psychological therapy such as cognitive therapy. This places the amelioration of our misery and suffering in the hands of experts: psychiatrists and psychologists. Many in the West now question this, especially those who use mental health services. Although some service users accept the idea that their suffering can be understood in biomedical terms, many British service users reject psychiatric interpretations of their experiences, and claim the right to understand their experiences for themselves. In doing so, they turn to spiritual, cultural, social, political and

sometimes alternative biological interpretations of their experiences.¹⁴ What are the global implications of this challenge?

The principal global protagonist of the biopsychosocial model is the extremely powerful alliance between the pharmaceutical industry and academic psychiatry. Information for service users on drug company websites frames psychosis largely in biological terms. Economic considerations mean that it is in the industry's interests to ensure that biological interpretations of psychosis dominate. The pharmaceutical industry is second only to armaments in the U.S. economy, and despite the economic uncertainties of 2001, it maintained its position as the second most profitable industry.¹⁵ Pharmaceutical companies are immensely powerful, and influential in the World Trade Organisation (WTO), one of the principal agents of globalisation. The WTO's global economic and political agenda is a matter of great controversy. Some describe it as a rich world agenda to keep the poor world poor;¹⁶ others have described the implications of the WTO agenda, led by the pharmaceutical industry and private insurance companies, for health care in the West. The opening up of the public health and social care sector to large multinational corporations jeopardizes local accountability, and is a major threat to democracy in health care. For its part, the WHO enthusiastically espouses the biopsychosocial model, and wants to see the governments of all the poor countries implementing plans for the identification and treatment of depression and schizophrenia. The WHO report (2001) establishes an agenda for the uncritical acceptance and dissemination of the biopsychosocial model across the world.³

Much the same can be said about the World Psychiatric Association (WPA), where the influence of the pharmaceutical industry is clear. At the Twelfth World Congress of Psychiatry organised by the WPA in Japan in 2002 there were many satellite symposia organised by pharmaceutical companies. Some dealt with the transcultural aspects of diagnosis: 'Psychiatric treatment of mental health disorders across populations - do east and west meet?' (Pfizer); 'Transcultural aspects of depression and anxiety disorders' (GlaxoSmithKline); 'Recognition and treatment of depression: Differences between American, European and Japanese practices' (Janssen-Cilag); and 'Eye on Asia: Reducing the socio-economic burden of depression' (Wyeth). Others dealt with the management of psychosis: 'Raising the level of schizophrenia care' (Janssen-Cilag) and 'Optimising patient outcomes in schizophrenia' (Pfizer). Nationally and internationally, the concerns of psychiatry and the pharmaceutical industry are becoming woven ever more closely together. This is fraught with dangers.

First, it hands a blank cheque to the pharmaceutical industry. If we think about ourselves and our problems, our suffering and our struggles, exclusively in medical terms then we set course for a massive increase in pharmaceutical sales. Second, it leads to a further aggrandizement of Western expertise at the expense of local understandings of distress. Most psychiatric research takes place in Western universities and research institutes. Poor countries simply do not have the resources to develop alternatives to Western biomedicine. Finally, globalization of the biopsychosocial model may undermine existing support systems for people experiencing mental health problems. Higginbotham and Marsella described the outcome of an earlier epoch of psychiatric neo-colonialism.¹⁷ They found that psychiatric care varied little in the capital cities of Southeast Asia, despite large cultural and linguistic differences between the people of these cities. The mechanisms of international mental health education, consultation and collaboration created a form of psychiatric practice that looked to the West for its conceptual foundations and for ideas about innovation and progress. The anticipated effect of these developments was better patient care, but the authors pointed to unexpected harmful consequences that meant that the care received by many people with mental health problems deteriorated. The diffusion of Western-based knowledge had undermined local indigenous understanding, healing systems and practices. This is arguably little more than a manifestation of neo-colonialism in the political domain of health.

Our own experience in situations of extreme dislocation and distress convinces us of the inadequacy of the biopsychosocial model as a response to the suffering of refugees. Bracken has described in detail the shortcomings of cognitive and positivistic science as a response to the suffering and trauma experienced by those exposed to war and civil conflict.¹⁰ For example, the concept of Post Traumatic Stress Disorder (PTSD) and therapeutic responses to this, all of which are deeply rooted in the Western concept of the interiorized self, fail to take into account the importance of the restitution of family ties, rebuilding communities and indigenous healing systems as a response to the dislocation and trauma of war. Instead of medicalizing distress and suffering, responses to trauma should aim at strengthening communities by providing them with the means to rebuild themselves. Summerfield has made similar observations. Like him, we argue that our response to suffering in whatever context should be primarily practical and ethical, not technological and medical.

AN ALTERNATIVE: COMMUNITY DEVELOPMENT AND LOCAL UNDERSTANDINGS OF DISTRESS

We want to end by briefly outlining how community development (CD) can offer a way forward by making it possible to engage with non-Western understandings of distress in an ethical and sustainable way. Higginbotham and Marsella's account of the failure of Western psychiatry to meet the needs of people in South East Asia resonates strongly with the failure of psychiatry in Britain to meet the needs of people from non-Western cultures. The evidence here is well summarised elsewhere,¹⁸ and consists of two main strands. First, some groups, especially African and African-Caribbean people, are more likely to experience coercion in care, and are over-represented in secure units. Second, patients from all Black and Minority Ethnic (BME) communities (this is the expression commonly used in England to describe people, whether born in England or overseas, whose family origins are to be traced to other parts of the world - in this context it particularly applies to people from South Asia, Africa and the Caribbean) are more likely to be dissatisfied with mental health services. The British government has expressed a commitment to rectifying these health inequalities, and its policy¹⁹ Delivering Race Equality (DRE) attaches particular importance to CD as a way of reducing fear in BME communities, and in helping to develop more culturally sensitive and appropriate forms of help for people from these communities.

We were involved in setting up a CD project, Sharing Voices Bradford (SVB) in 2002 (for further details, see <http://www.sharingvoices.org.uk/index.htm>). Nearly 60% of the population of inner-city Bradford are from South Asian (largely Pakistani) or African and African-Caribbean communities. SVB is a community development project that focuses on mental health. It works with South Asian, African, African-Caribbean and other communities in Bradford to find alternative and new forms of support for those experiencing distress. It uses community development (CD), premised on the belief that poverty, racism, loneliness, relationship difficulties, domestic violence, sexual abuse, and spiritual dilemmas are often at the heart of mental health crises. CD focuses on improving well-being by addressing economic, social and environmental factors, with a commitment to equality and empowerment. It provides an opportunity for people to acquire skills and confidence in devising their own responses to distress. It fosters a sense of ownership of their services and reducing dependency on others. Cohesion and social inclusion are recognized aims of CD.

The key feature of Sharing Voices Bradford is that it is at an arm's length from statutory services, and rooted in the

communities that it serves. It is thus in a strong position to engage local people, support them to develop a voice and be heard by statutory service providers. It is now established as an independent non-governmental organization (charity) accountable to the local communities, but with close links with mental health services and an academic partner. The project has five staff, including four community development workers and a co-ordinator. It works across all Black and Asian communities, identifying shared concerns whilst respecting differences. This resonates deeply in Bradford where communities, even within the majority Pakistani population, have been described as fragmented and suspicious of each other. CD lies at the heart of many activities in the city following the riots of 1995 and 2001, aimed at building community cohesion.

SVB's aims include:

- enabling people who experience mental health problems, their families and others, to develop sustainable solutions within the community
- liaising with statutory service providers to improve the range and quality of services
- stimulating a wider debate locally, nationally and internationally about the nature of mental health, diverse perspectives and ethnicity.

The workers have successfully engaged a wide variety of individuals, families and communities, including key gatekeepers and existing voluntary/statutory sector organizations that focus on mental health, and many that work outside the traditionally defined boundaries of 'mental health', such as the countryside services, Bangladeshi Youth Organization, and youth services. This requires perseverance; much time is spent listening and talking to people in a wide variety of locations, informal and small local networks, often with no immediately obvious outcome. However, over time the workers have successfully developed relationships built on trust, with an open and honest approach that acknowledges the limitations of mainstream mental health services. This has resulted in the development of several community groups. Many of these are gender and faith specific; some are neither. Hamdard, for example, is run by South Asian women who have experienced distress, and who found a road to recovery in their Islamic faith and peer support. On the other hand, the Creative Expressions group has brought together culturally diverse women, to share their experiences of distress and oppression, and to express this through poetry and painting. A fitness group has brought together men from a variety of cultural and religious backgrounds who find physical sports and fitness to be a valuable way of coping with distress. The group helped to increase the men's confidence and helped to create a strong bond between them.

In 2006, SVB carried out a community engagement project that explored the needs of Bradford's diverse Muslim communities. The researchers were recruited from the local Muslim communities and 97 participants were involved in communicating their views on mental health, local mental health services, and the kinds of support they would like to see at times of distress. One of the key recommendations of the report involved access to an Imam or someone with detailed knowledge of Islamic spiritual and religious discourse to help Muslim people in distress make sense of their experiences. The project is still very much in its early days, but early outcomes are positive with people valuing a spiritually informed perspective to help them understand their experience, and resolve issues in their life such as relationship difficulties, all within an Islamic framework.

Bradford is one of seventeen focused implementation sites (FIS) for the implementation of the government's Delivering Race Equality program in mental health policy. The Community Development Workers (CDWs) are central to the delivery of this national policy, and in supporting statutory services to meet the requirements of the DRE by developing culturally sensitive services. The recommendations coming from the Community Engagement Project and SVB are shaping local mental health services, and making them more sensitive to the needs of diverse BME communities, including Muslim people in Bradford. The local provider has taken a bold approach to implementing the faith and spirituality agenda for people from different faith traditions, and is currently working towards employing chaplaincy staff, including Imams, as part of in-patient mental health teams. In addition a taught module at the Master's level is being developed with an academic partner on faith, culture and spirituality, to increase the cultural competence of professional staff.

CONCLUSIONS

We have drawn attention to some shortcomings of Western models of psychiatric disorders, and drawn attention to the harm that may arise from over-zealous attempts to impose Western understandings of distress on non-Western cultures. We have also briefly outlined an alternative approach that uses community development to engage with local understandings of distress. We are not advocating a wholesale abandonment of Western psychiatric knowledge and practice, but one that sees local understandings and practices as having at least as much value as Western ones. We live in a world that is marked by polarities and intolerance, and it is essential that our work with people in distress should transcend this. Nature and nurture are both important, but across

the globe we are under pressure to adopt a biological perspective to the exclusion of all else. This is wrong because it excludes our common sense human understanding from our work. This is deeply rooted in our respective cultural traditions, and these traditions in turn are of immense value in helping us understand our lives. Biology imposes a uniform sameness that obscures our vital human differences. It is essential that we respect and value our cultural differences as we struggle to understand ourselves and the world we live in.

REFERENCES

1. Klerman GL. The evolution of a scientific nosology. In: Shershow JC (ed.) *Schizophrenia: Science and practice*; Cambridge, Massachusetts: Harvard University Press 1978:99-121.
2. Johnstone EC, Crow TJ, Frith CD, Stevens M, Kreef L, Husband J. The dementia of dementia praecox. *Acta Psychiatrica Scandinavica* 1978;**57(4)**:305-24.
3. WHO. *World Health Report 2001: Mental Health: New Understanding, New Hope*. 2001.
4. Bracken PJ, Thomas P. Postpsychiatry: a new direction for mental health. *Br Med J* 2001;**322(7288)**:724-7.
5. Bracken PJ, Thomas P. *Postpsychiatry: Mental Health in a Postmodern World*. Oxford University Press; 2005.
6. Jaspers K. *General Psychopathology* (English translation by J. Hoenig & MW Hamilton). Manchester: Manchester University Press; 1963.
7. Wittgenstein L. *Philosophical Investigations*, tr. GEM Anscombe: Blackwell; 1968.
8. Ingleby D. Understanding 'mental illness'. In: *Critical Psychiatry: The Politics of Mental Health*. London: Penguin; 1981:23-71.
9. Davies P, Thomas P, Leudar I. Dialogical engagement with voices: a single case study. *Br J Med Psychol* 1999;**72 (Pt 2)**:179-87.
10. Bracken P, Summerfield D. Trauma: Culture, Meaning and Philosophy. In: *Br Med Assoc*.
11. Thomas P, Bracken P, Leudar I. Hearing voices: A phenomenological-hermeneutic approach. *Cognit Neuropsychiatry* 2004;**9(1)**:13-23.
12. Miller P, Rose N. *The Power of Psychiatry: Polity Press*; 1986.
13. Miller P. Critiques of psychiatry and critical sociologies of madness. In: *The Power of Psychiatry: Polity Press*; 1986:12-42.
14. Faulkner A, Layzell S. *Strategies for living: A report of user-led research into people's strategies for living with mental distress*. London: Mental Health Foundation; 2000.
15. Citizen P. Pharmaceutical industry ranks as most profitable industry -- again. Drug companies top all three measures of profits in new Fortune 500 report In: *Public Citizen's Congress Watch*; 2002.
16. Price D, Pollock AM, Shaoul J. How the World Trade Organisation is shaping domestic policies in health care. *Lancet* 1999;**354(9193)**:1889-92.
17. Higginbotham N, Marsella AJ. International consultation and the homogenization of psychiatry in Southeast Asia. *Soc Sci Med* 1988;**27(5)**:553-61.
18. Walls P, Sashidharan SP. Real voices: Survey findings from a series of community consultation events involving Black and Minority ethnic groups in England. London: Department of Health; 2003.
19. Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett. London: Department of Health; 2005.