Indianizing psychiatry – A critique

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ABSTRACT

The issue of culture in Indian psychiatry has endured increasing neglect with the burgeoning biological paradigm. This viewpoint debates and demystifies the connotation of “culture” in mainstream psychiatry. As a template to infer dominant thinking in mainstream psychiatry about culture, DLN Murty Rao Oration in 2011, “Indianizing Psychiatry – Is there a case enough?” by Avasthi (2011) (published in the Indian Journal of Psychiatry) has been used. Engaging a broad interdisciplinary view helps unravel the inherent biases in psychiatry and opens up space for analysis of the Indian psyche from a different philosophic tradition and ways of researching it. Effort here is to open up dialog with cultural psychiatry, make efforts to involve traditional and folk therapies, and use available theoretical and empirical resources within cultural psychiatry for a refined practice of psychiatry in India.

Key words: Culture, Indian psyche, mental health, philosophy, psychiatry

INTRODUCTION

Indianizing or indigenizing psychiatry is about realizing India’s sociocultural realities. DLN Murty Rao Oration (2011) attempts bringing “culture” to the fore in the context of psychiatric practice.[1] The oration titled in the form of a question “Indianizing psychiatry – Is there a case enough?” (henceforth referred to as “Indianizing psychiatry”) attempts answering this in affirmative. We, on the other hand, use “Indianizing psychiatry” as a template to infer and critique dominant thinking in mainstream psychiatry about culture. Critique here means an analysis that is in-depth, self-reflective, using concepts outside a single discipline to understand human interaction and intervention as a social phenomenon. Thus, we unpack the meaning of culture and attempt to provoke the readers to be self-reflective of their practice of psychiatry and engage a critical psychiatry perspective.

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We beg not to assume any personal vendetta in this critique. We rather acknowledge and are in agreement with a more conceptually refined later paper on a similar theme[2] by the author of “Indianizing psychiatry.” We attempt to further these refinements as well, through a critique.

We start with two guiding questions to give direction to the discussion. First, has the case been made enough to claim Indianization of psychiatry, and second, what rough shape that Indianized psychiatry will assume (in research, theory, and practice)? We have written a shorter response earlier,[3] but here we develop and expand those arguments for a more general purpose. Moreover, psychiatry as practiced in India today has turned too biological rather than truly biopsychosocial. Although early attempts in Indian psychiatry intended to integrate cultural understanding as evidenced in the works of Rao,[4,5] Vahia et al.,[6-8] Neki,[10,11] Varma,[12] Satyanand,[13] Mahal,[14] and Varma,[15] but in the last two decades, this is not so.[16] On this account, the younger generation of psychiatrist needs to develop a critical view of psychiatry for a more nuanced practice.

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We follow the broad structure of “Indianizing psychiatry,” i.e., discuss the uniqueness of psychiatry from rest of medicine, elaborate on the idea of Indian psyche and unique coping styles, deliberate on the complexities of psychiatric categories, and show importance of culture in psychiatric services and therapeutics. We conclude proposing an epistemological shift for the integration of culture in psychiatric theory and practice.

UNIQUENESS OF PSYCHIATRY? AND THE “REST OF MEDICINE”

The psyche is “intangible, effervescent, and indefinable,”[1] especially when meeting of minds through social exchange defines psychiatric diagnosis, treatment, and outcome. This is partly true for engagement with any of the following human condition: physical or mental illness and social or economic crisis. Thus, considering this line of thinking problem definition (diagnosis), solutions (treatment) and results/outcome are shaped by the communication skills, personality, sociocultural beliefs, and most importantly interpretations of those involved in these intimate or formal (social) exchanges. Here, those involved may include not only the “clients” but also the clinicians, psychiatrists, social workers, researchers, policymakers, or politicians. The intention is to bring in a broader imagination of the workings of society and a tendency of thinking about medicine/psychiatry within this social structure.

There truly are vast differences between humans in various “cultures, traditions, and religion;”[1] hence, differences in understanding of normality/abnormality and health/illness which we recognize are emergent from historical, social, cultural, technological, and political processes. As an elaboration take the example of culturally specific syndromes in psychiatry that has no equivalent manifestation outside those cultures. By the same token we find differences in understanding of aging across different continents or time[17] either as an undesirable process bringing one closer to death or a desirable accomplishment of accumulating wisdom. Or may be consider the flip-flop of mammography in breast cancer screening where some years ago it was considered mandatory but now considered waste (thus showing the interaction of technology with time). However, conventional thinking and “Indianizing psychiatry” assumes uniqueness of psychiatry (mental illness), unlike chronic physical illnesses; implicitly conveys mind-body dualism. Such is the hallmark of psychiatric reasoning in general (as seen in an empirical analysis on psychiatrists and psychologists at McGill University[18]). We argue that their similarity is not only in their incurableness but also on many other accounts. Such as pharmacological interventions in common chronic medical diseases (hypertension, stroke, type 2 diabetes, etc.) and psychiatric disorders have comparable effectiveness (as shown by similar effects sizes of small to medium).[19] The role that sociopolitical interventions have in partly addressing human health, such as the importance of improved living standards, economics, and redistributive politics in bringing down mortality rates in the nineteenth century England and Wales rather than medical innovations of vaccines or antibiotics[20,21] versus improved mortality outcome of the mentally ill following a deinstitutionalization policy in a sociodemocratic political climate in the Nordic countries.[22,23] Even causal mechanisms of medical and mental conditions share degrees of similarity when considering the shift in epidemiological theory with the progressive change of monocausal explanations given by the germ theory of disease to multicausal chronic disease epidemiology to finally explicate a complex eco-epidemiological explanation for health and disease.[24,25] Simply take the example of the “Dutch famine birth cohort study” showing multiple health outcomes (both medical and mental- type 2 diabetes, obesity, coronary heart disease, schizophrenia, depression, accelerated ageing) from a common exposure of famine in utero as a result of war.[26,27]

The assumed diagnostic uniformity in chronic physical disorders (versus mental illnesses) does not reflect as uniformity of practice (in diagnosis and often in treatment) in widely different cultures, social settings, over different time periods, and in different health systems. One can take the case of diabetes in this regard. Without dwelling into the underlying rationale, the definition of diabetes has kept changing over time[28] and its management varies by context without having implications for outcome.[29] Conversely, attempt at expert-driven diagnostic (and management) uniformity is also a truth for psychiatric disorders. Thus, a broader systemic view questions whether the “uniqueness of psychiatry” is indeed so obvious.

Attention to cultural differences and awareness of incongruent Western categories to Indian settings go hand in hand. But if we consider “the average Caucasian as the model of diagnosis and treatment...”[1], we are unfair as we ignore the racial and the gendered angle of this phenomenon. Rather, the diagnostic systems considers the “average white male” as the model for normality[30] and a reference to judge, for example, a suicidal black teenage mother or a tribal woman survivor of abuse.

Therefore, rejecting such categories as naturally given opens up opportunity to start bottom-up from symptoms, to take note of culture and their dynamic contexts. A suggested model is the ecosocial phenomenological approach where mental distress and symptoms are assumed to interact reciprocally to cultural expectations and social responses, generating particular patterns of cultural syndromes, explanatory models, folk categories, and experience.[31] For example, instead of starting with
Depression as a clinical category, the task is to identify clustering of symptoms such as anhedonia, weight loss (assumed core symptoms) with culturally patterned symptoms of dissociative possession, or unexplained physical symptoms and identify their distribution, determinants, and outcome. This might help to understand indigenous theories of mental illnesses.

**CONSTRUCTION OF THE INDIAN PSYCHE AND COPING STYLES**

In general, when members of a culture are considered as a whole, Eastern/oriental philosophies have constructed individuals as living within a flux of interlinked and interdependent others whereas the Western/occidental ones find them to be individualistic and independent. At the same time, it should also be considered that individuals belonging to either world (especially in this modern globalized world) are porous to both philosophical influences only differing in degree. In fact, this systematic influence of culture on self-construction has implications for psychological concepts such as cognition, emotion, and motivation. “Indianizing psychiatry” elaborates on the relational/sociocentric aspect of Indian culture but concludes the modern “fragmented, multifaceted Indian self” having contradictory beliefs, attitude, and behavior, which again resulted from an identity crisis due to the onslaught of British colonialism (adapting Ajita Chakraborty understanding). It has been discussed elsewhere that these processes are rather universal and not exclusively Indian. Discursive psychology deals particularly with this aspect, which unlike conventional psychological understanding assumes attitudes and behavior as dynamic and contextual rather than stable human characteristics. It focuses on how identity, subjectivity, and agency are constructed within available personal, familial, social, and cultural discourse, opening up various “interpretive repertoires” making way for a socially emergent self. Humans position themselves in a context-dependent manner achieving intersubjective meaning (shared understanding) in a social interaction. Thus we see compartmentalized and mutually contradictory ways of dealing with various social and personal situations that define self and identity. Like, for example, a medical doctor prescribes antibiotics and cough lozenges to patients with cough and cold but recommends honey and tulsi for remedy for his adolescent child with similar complaints.

Even cognitive representation of culture is suggested to exist as disparate bits of information partially organized through cultural schemata. These schemata are strategically invoked depending on external cultural cues allowing the participation in multiple cultural traditions. Culture then not only becomes constraining but also enabling. Thus, humans have the opportunity to use different available cultural resources to deal with variety of situations. Consequently, we see universally, people participating in/maintaining different cultural tradition containing inconsistent elements, depending on varying context. Therefore, compartmentalizing identity models to respond to different contexts in a different manner is ubiquitous rather than exclusively Indian.

But what is distinctive is the “Indian” historical and sociocultural influence on “compartmentalization and contextualization.” It is not just colonialism, traditional values, and modern ways of life as suggested by Chakraborty. Culture is carried by institutional structures (viz., Indian family and its associated changing value, caste system and its attendant dynamics), formal professional and informal social networks, and social movements (e.g., the recent movement for Jan Lokpal bill or the Nirbhaya movement). Thus, issues of social position/hierarchy, class relations, caste dimensions, religious affiliation, and the political trends need to be considered to understand the influence of culture on Indian psyche and collective identity.

In addition, conventional thinking suggests predominant religious ways of coping in Indians, attributing it to cultural tradition. We make a few more observations. Coping mechanisms can be problem focused or emotion focused. People cope through the latter method (which includes spiritual/religious ones) when they have less/no resources to buffer them and/or when stressors are uncontrollable. Resources can be internal or (material) external. Even internal resources (such as optimism, mastery, and self-esteem) are much influenced by the material world (socioeconomic status and safe environment) during early life. Thus, religious means of coping and submitting to God is as much due to tradition as it is due to scarce instrumental coping resources.

**DIAGNOSIS, ETIOLOGY, AND PROBLEM DEFINITION: CLINICAL SYNDROMES**

The concept of “category fallacy” describes the narrow boundaries drawn by Western diagnostic systems to fit non-Western phenomena, missing out important manifestations. This has resulted in recent debates on the validity of psychiatric nosology. Instead, diagnostic utility is currently being pitched as the aim to refine classificatory systems. Utility, on the other hand, is subject to changing value systems of society. It also varies by context, individuals, and groups. Thus, who defines diagnostic categories – Psychiatrists? Doctors? Mental health professionals? Social scientists? Policymakers? Political parties? or People in general? And such categories benefit whom?. This is important as can be seen in the history of Diagnostic and Statistical Manual of Mental Disorders (DSM) with homosexuality, where gay rights activism had redefined a diagnostic entity and leveraged on the concept of utility. Kirmayer warns that the ways, by which psychological decomposition is defined and psychiatric categories
are constructed, need evaluation within the context of global systems of knowledge generation and power. As a window to make sense of how knowledge and power interact considers the conflict of interest of DSM panel members (in terms of financial ties to the pharmaceutical industry) who are tasked to define diagnostic categories there by having a subte influence on the process.\textsuperscript{49} Hence, when a biomedically trained psychiatrist sets about the task of validating (Western) diagnostic systems, it has implications for presumed etiology (i.e., the cause is thought to be residing in the individual) and (individualistic) solutions (pharmacotherapy and psychotherapy).

\textbf{(CULTURALLY APPROPRIATE) SERVICE DELIVERY SHORTAGE OR MENTAL HEALTH ILLITERACY}

Western-influenced research explains that the reason for lack of utilization of mental health services or the neglect of medical care of the mentally ill is due to poor mental health literacy;\textsuperscript{46} however, this becomes a form of victim blaming. Rather, people opting for folk practitioners are partly traditionally inspired and partly due to the lack of availability/affordability of health services. This historical deficiency also has reciprocally influenced the predominant form of general thought and beliefs about psychiatric problems (thus mental health cultural incongruence to “Western” psychiatry). This may be the reason why we see variation of response/attitude toward mental illness. This has been true in other parts of the world as well.\textsuperscript{47} The incongruence in rural communities’ felt need and mental health services in India are widely prevalent.\textsuperscript{48,49} Ethnographic research\textsuperscript{50,51} on people attending shrine healing points out that not only the lack of economic resources but also the incongruence in biomedical versus local explanatory concepts related to etiology of mental illness and differences in professional conduct of doctors versus faith healers repel people from seeking biomedical treatment and preferring alternative therapies (faith healing especially). Here, mainstream psychiatry has seldom seized the opportunity to collaborate with AYUSH streams, despite generating good amount of discussion on their potential for Indianized psychiatry can possibly be instituted after AYUSH is mainstreamed into public health services.

\textbf{TREATMENT, AMELIORATION, HEALING, AND PREVENTION}

The consideration for Indianization of psychotherapeutic practice is just. However, a critical appraisal of any (psycho) therapeutic encounter ought to be aware of the power differentials in such setting. This can be thought as Neki’s\textsuperscript{52} concept of guru-celā (master/pupil or disciple) relationship or as in the reproduction of social hierarchy in the healing rituals of folk medicine.\textsuperscript{53} While if symbolic value is considered, faith healing rituals have much in common to Western psychotherapeutic practices.\textsuperscript{54}

Moreover, any practice of therapy (that manipulates Indian psyche) requires robust theory that includes in its understanding the “social” in a therapeutic relationship; the historical, cultural, and material influences on the Indian psyche and social life; the concept of self and the symbolic and meaningful aspects of healing traditions. Dwelling into such issues is more to address the general (rather than specific) ingredients of therapy, namely, therapeutic relationship, hope, and meaning and normalize distressing experiences that are significantly more important\textsuperscript{55} and have a larger share (about 85\%) in influencing therapeutic outcome.\textsuperscript{56}

Moreover, traditional Indian concepts do not differentiate body and mind (as in Western thoughts) but rather conceptualizes spheres such as body and spirit (or soul). Hence, the Indian psyche often confounds mental happiness and health with spiritual development. This has particular relevance to (psycho) therapy and psychiatric patients.\textsuperscript{57} Thus, a dilemma arises, who is to address the “spiritual” in therapy; a guru, the mental health practitioner;\textsuperscript{58} or a faith healer using the spirit medium. At the same time, one cannot deny transformations taking place in traditional and faith healing practices. Such as the modern practice of Ayurveda, contaminated by biomedical sciences, in terms of proving its evidence base (through randomized controlled trials in ayurvedic drugs) and practice orientation (in terms of its commercialization and professionalization).\textsuperscript{59} Furthermore, Indianized psychiatry needs to define the role of organizations such as Brahma Kumaris, Sri Sri Ravi Shankar’s Art of Living, the export and reimport of Transcendental Meditation, Satguru’s Isha foundation, and Baba Ramdev’s Patanjali Yogpeeth among many others. These organizations have used Indian concepts of yoga and its philosophical traditions and claim to improve lifestyle diseases and common mental disorders. Thus, culturally appropriate forms of healing and their dynamics in terms of power differentials, meaning generation, family role, manipulation of Indian psyche, and addressing spiritual development within the healing context need further elaboration and study to better understand and modify mental health services. At the same time, one should recognize that at the individual clinical level, a mental health practitioner is also influenced by these concepts and use them to varying degrees in their therapeutic work.\textsuperscript{60,61} The foregoing issues are even more relevant when considering preventive efforts, as power differentials bring out the relevance of politics in policy, programs, and problem definition.

\textbf{NOTES ON “WESTERN” SCIENTIFIC METHODS AND ABSTRACTIONS OF HUMAN NATURE}

This section provides a background to the epistemological, cultural, and biomedical biases of modern psychiatry. This
is to clarify the second question that we had brought up, in the beginning, i.e., what rough shape will that Indianized psychiatry assume?

The methods of research and knowledge generation (the theory of knowledge/epistemology) in scientific practice, is grounded on the Western Enlightenment—the Age of Reason. The Enlightenment thinkers were inclined to atheism, away from supernatural elements (devaluing local “prejudices”), thinking the universe to be a rational system, wholly accessible to human reason. Its ahistorical nature assumes that all people at all times (and in all places) are fundamentally the same in nature. Its basis is in scientific objectivity and progress. Psychiatry, a child of Enlightenment, is based on a medical model and positivistic approach (which relies on quantifiable observation, experiments, and statistics) that has been criticized for seeking an elusive “objective” knowledge (a search for facts). Driven by positivism to find objective facts psychiatry assumes psychological states can be examined in isolation from the world around them. This, introduces an “epistemological dualism,” i.e., the separation of the inner world of mind from the outer world, where the examiner is presumed to stay separate from what is being examined without influencing or being influenced by it in any way. This is despite the fact that the examination happens in an interactive social environment, unlike a chemistry experiment. This separation of the two worlds has objectified the inner workings of the mind. This alienates the produced objects (herein the biomedical bias) from the producer, conveying value neutrality. The posture of value neutrality is in itself the bias hidden within scientific methods and discourse that figure out pathologies within the individual biologies. Thus, it becomes evident why the diagnostic manuals in psychiatry have assumed the average white male as normal. In a different strand, as per Foucault, this objectification transforms human beings into subject constraining, for example, a “black” teenage American single mother to emulate the norms of a White male.

When critically exploiting objectivity, methods within psychiatry then exposes how objectivity if manipulated do not serve science. Take the example of pharmaceutical trials/markets. Other than the drawbacks discussed within medical literature, a political-economic analysis shows how it is used as a tool to achieve corporate profit-driven economic ends which cannot be strictly called science. Science then becomes a handmaiden, a tool to achieve completely different ends.

The assumption of psychiatry regarding epistemology in mental health sciences is that the body has a common biological basis upon which culture acts in multiple ways. Anthropological research has questioned this notion and unfolded the critical interaction of the biological and the social body.

In sum, the scientific, nonreflective research ignores its own contamination by political interests. Habermas cautions us about the positivistic dichotomy of knowledge and interest and instead suggests that valid science recognizes its own foundation in interest and social context.

Taking this as an introduction to build further for a research direction in the study of culture, the inclusion of culture as an independent factor in epidemiology is easier said than done. Using ethnic and racial categories to imply cultural explanations in epidemiology (an example of cultural turn in Western science) tells us little about how culture shapes the perceptions, expression, local idiom of distress, and responses to physical/mental strain. In future, studies must begin to develop and include measures that function to directly assess the multiple facets of culture.

Quantitative research (epidemiology) may have to fumble with the amorphous and subjective variable, i.e., culture. In fact, studies that have tried to understand the cultural influences on psychological distress have used qualitative methods. Ethnography can be used then to supplement epidemiology. On the other hand, research itself can be biased in terms of the way how one looks at the subject: culture. The apparent objectivity in medical/quantitative research is biased in terms of finding an objective disease entity colored by subjective bias of its objective existence. Diagnostic entities itself can be thought to be socially emergent from historical, social, cultural, and technological processes, a concept most relevant to psychiatry than any other stream of medical discipline. Thus, as the philosopher Bhaskar notes, “society does not exist independently of conscious human activity (the error of reification). However, it is not the product of the latter (the error of voluntarism).” Simply, our being cannot always be analyzed in terms of our knowledge (of being).

CONCLUSION

Concluding from biomedical, psychological, sociological, anthropological, and philosophical account, what is considered to be a simple transparent task of “validation” is actually a more complex and obscure endeavor. Indian mainstream psychiatry assumes culture to be of secondary importance and is a poor caricature of the Western model, incongruent to the realities and needs of the Indian population.

Thus, Indianization of psychiatry then becomes a huge project yet inherently important.

The endurance of this project, to us, is conceptually dependent on an exclusion of mind-body dualism, consciousness of how the practice of medicine/psychiatry is set within and influenced by the social structure and workings of society. Moreover, Indian psyche needs to be understood.
within the context of society, its history and its culture defined by the prevalent social institutions, networks, and social movements. Moreover, clinical syndromes need to be worked upward from symptoms to syndrome to redefine psychiatric categories. A self-reflective practice then is aware of the political economy and power dynamics in psychiatric diagnostic systems and the therapeutic milieu as well as the socioeconomic realities of the clients/patients. Time is also opportune to collaborate with AYUSH streams. Finally, an epistemological shift in research and practice would allow an ethical enhancement to realize one’s own biases and interest.

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