

*Letter to the editor*

## Some reflections on the article of Vikram Patel ‘Rethinking mental health care: bridging the credibility gap’ in the *Intervention* Extra Issue: *New Frontiers*

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In his article, Patel (2014) goes a long way to bridging the gap between the global and transcultural mental health movements, a divide that has inflamed much passion in recent times. As a watershed moment in the field, Patel’s article deserves to be widely disseminated and carefully studied. Here, I offer feedback in the spirit of encouraging constructive debate that may move our field closer to a synthesis of ideas and practices.

Like many others, Patel is critical of applying contemporary international diagnostic systems across cultures. He rightly identifies a credibility gap between the dominant world view of mental health (represented by professionals from high income countries) and the lived experience of the majority, i.e. people residing within diverse cultural settings in low and middle income countries. The solution, he argues, is to base our clinical formulations on local understandings of mental phenomena, what has traditionally been referred to as the *emic* approach, in which cultural idioms of distress are embedded in local explanatory models that confer meaning to experiences of suffering and healing. Few would argue with this position. Often, mental health concepts imported from high income countries (the *west*) seem to be alien and decontextualised when applied across cultures. In addition, by claiming access to privileged knowledge,

expatriate *experts* risk perpetuating entrenched, post colonial power imbalances. As we well know, knowledge is power.

The ideal solution is to work towards reconciling and integrating the *emic* and *etic* perspective into a coherent framework that makes sense within each cultural setting. Nevertheless, although efforts have been made to graft culture onto international classification systems, existing models are still far from satisfactory. In fact, as yet, there is no comprehensive nor clearly specified set of procedures to guide researchers or clinicians in the process of integrating these two world views. This is a critical area, where the global and transcultural mental health movements should come together, to work towards achieving a consensus on the way forward.

Patel focuses particularly on the drawbacks of a categorical approach to diagnosis, drawing on the results of contemporary psychiatric epidemiological studies to support his critique. The only credible explanation for the very high rates of ‘*common mental disorders*’ yielded by these studies, is that most of the people identified are experiencing situational forms of distress, and therefore, not diseases or disorders in the sense that these terms are used in physical medicine. There is much truth in Patel’s claims, but the problem is that we do not yet have the tools, either clinical nor scientific, to distinguish

clearly between disorder and distress in mental health. There is ample evidence that shows that even experienced clinicians disagree when trying to find the dividing line between a case and a non case, and current statistical techniques have so far failed to help overcome this problem.

It is for this reason that the alternative dimensional approach has been so often promoted in recent times; instead it provides a model in which symptoms are recognised as falling on a continuum, ranging from mild to severe. However, the dimensional approach has problems of its own. It is difficult to train newcomers in the field using complex multi-dimensional or multi-axial models. There are other formidable challenges in using a dimensional approach in research, particularly when the aim is to identify the number of people within a community requiring treatment. Further, within clinical settings, the dimensional approach makes it difficult to specify guidelines for treatment that would allow workers to use a rule of thumb to decide who should get what. From a public health perspective, trying to argue for funding, based on a dimensional perspective is likely to reduce the credibility of mental health even further, a risk we take in a world where the status of our discipline cannot afford to fall even lower.

In summary, there are good reasons why mental health professionals cling to the categorical/diagnostic approach. However imperfect, the common language offered by universal diagnostic terms helps to facilitate transnational communication, sharing and comparing of knowledge, estimation of community needs, and standardisation and benchmarking of practices. The error we commonly make, however, is to treat diagnostic categories as if they are concrete or *real* entities (the fallacy of reification), rather than representing the best approximations we can make of common patterns of mental distress at any point in time. In that sense, diagnosis is a useful abstraction, not an

indicator of a psychopathological process that can be confirmed under the microscope. Perhaps at the root of many of our conceptual problems is the artificial distinction we make between mental and social worlds (the Mental–Social Gap). Patel makes the point that there is a qualitative difference between mental disorders and physical diseases. One of the key reasons is that physical organs such as the kidney (or liver, or heart) have no direct window onto the outside world. In contrast, the brain is a social organ – although locked physically within the skull, its frame of reference is the entire universe (reflected in its capacity for perception, interpretation, thought, reflection and initiating action). Yet for some reason, we stubbornly cling to the notion of a division between the mental and social worlds. Admittedly, biological substrates mediate sensory inputs, but the social world is of primary importance in assigning meaning to experience and shaping our responses in a way that, in mental health, leads either down the path to adaptation (which we call health) or, alternatively, to dysfunction and suffering.

Perhaps our core problem is that we allow our disciplinary backgrounds and ideological/epistemological allegiances to strait-jacket us and pigeon hole others, dividing us into those who adhere to the medical/biological or social models.

Many of the controversies, questions and philosophical differences that are evident in the field can be traced back to this false dichotomy: debates about whether trauma (as a medical/psychological form of ‘injury’) or adverse social conditions in a post conflict environment, are “*more important*” in determining the mental health of refugees; whether we should build resilience, or treat people for their intrinsic vulnerabilities and psychopathology; whether we should focus on the individual or the collective; whether the PTSD reaction is a biomedically defined mental disorder, fixed in the circuitry of the brain, or represents a

barometer of the overall level of eco-social threats experienced by the community; and, whether we should focus on offering clinical services or psychosocial programmes. The list goes one.

If considered from this vantage point, the real value of epidemiological data accrued in our field is the close nexus that this body of work has demonstrated between the social and the mental worlds. Populations exposed to human rights abuses, mass disruptions and gross deprivations, regularly and predictably manifest high levels of mental distress. Mental distress, in turn, impacts adversely on individual and collective functioning. This is a reflexive process which, if not addressed, can lead to vicious cycles of suffering, disability and even recurrent violence. Restoration of the psychosocial structures that promote functioning, therefore, is key to mental health recovery at a population level, a lesson that has implications that go beyond the limits of our field. Nevertheless, it is also vital to recognise that, in any society, there is a core group of people with disabling mental states (whether diagnosed according to western or indigenous categories) who are in urgent need of specialist assistance. The treatments we can offer are moderately effective, and in most cases, the benefits outweigh the risks (the risk/benefit ratio becoming more favourable where skills, knowledge and resources are higher). Failure to provide treatment to those in need is a violation of the rights of the mentally ill.

Highlighting that reality brings us to the final gap, the one that divides the ideal from the pragmatic. We all know that the majority of the world's population has no, or very limited, access to mental health services. The standard practice model, at present, is a long line of patients waiting outside health posts in the hope of receiving some relief from their suffering. The mental health worker (if there is one), faces the daily challenge of attending to an overwhelming list of patients, within a context of isolation, limited resources, little or no access to supervision and/or training, and few opportunities for career advancement. Even if the pace of change is slow, incremental improvements to this dire situation are better than none. At times, therefore, our debates may seem somewhat rarefied given the extent of unmet needs. Yet, at the same time, we need to be clear about our premises and the models we draw on when offering assistance, so as to avoid the worst transgression of all, which is to do more harm than good.

## Reference

Patel, V. (2014). Rethinking mental health care: bridging the credibility gap. *Intervention*, Extra Issue, 12(4), 15-20.

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