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interdisziplinärer Verhandlungsraum

KEM -T#2

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POJHA ÑAÑA

Materie Medica Misionera

o

Herbario de les Reducciones Guaranies

Misiones

Año de 1725

por

MARCOS VILLODAS S.J.

AGEM 1970–2010: 40 Jahre Forschen im „Interdisziplinären Arbeitsfeld Ethnologie & Medizin“. Rückblick und Ausblicke II: Anwendungen

Zum Titelbild/Cover picture 33(2010)3+4:

Abbildungen zu Artikeln aus diesem Heft:
links: die Göttin Tanit (Ibiza) / **Mitte oben:** Der Patient als Integrator; **unten:** Ifa-Orakelbrett /
rechts oben: Flowers in Memory of Mortal Road Accidents, Lady Diana in Paris;
unten: Ethnobotanik der Guarani 1725

Figures of articles in this issue:
left: Goddes Tanit (Ibiza) / **middle up:** The Patient as Integrator; **below:** Ifa-oracle /
right above: Flowers in Memory of Mortal Road Accidents, Lady Diana in Paris;
below: Guarani Ethnobotany in 1725.

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Mental Health in the Developing World: Considering Local Human Resources*

PETER KAISER

Abstract Mental disorders are highly prevalent in many developing countries, yet shortages of specialists and appropriate health facilities are common, especially in rural areas. Still, mental health experts from developed countries need to be careful when exporting knowledge and be conscious of indigenous health system structures. Mental health programs should not only be based on scientific analysis and empirical evidence, but stimulate mechanisms of adaptation of local knowledge and foster self-help to minimize helplessness. To avoid top-down health policy, any approach in providing mental health services should be discussed with the local authorities as well as representatives of the prevalent religious or other interest groups. Individual-centred western psychotherapy may be not the right approach to help in some regions of the world with community-based cultures. Without restoring at least some of the main protective factors (e.g., integration in family or community, work, belief system and transcendence) perhaps existing psychological wounds cannot heal. Both public education for the rural population and mental health training for health workers is important not least due to their common environment and cultural background.

Keywords mental health system – mental health disorders – training – indigenous culture, developing country

Behandlung psychischer Störungen in Entwicklungsländern unter Berücksichtigung lokaler Ressourcen

Zusammenfassung Psychische Störungen sind in vielen Entwicklungsländern weit verbreitet. Insbesondere in ländlichen Gebieten fehlt es an Spezialisten und an passenden Behandlungsmöglichkeiten. Spezialisten aus industrialisierten Ländern sollten beim Import von „Hilfeleistungen“ Vorsicht walten lassen und auf vorhandene Strukturen des Gesundheitssystems Rücksicht nehmen. Gesundheitsprogramme für psychische Störungen sollten wissenschaftliche Qualitätskriterien erfüllten, gleichzeitig jedoch auch lokales Wissen berücksichtigen und zu integrieren versuchen. Zur Vermeidung paternalistischer Tendenzen ist eine enge Zusammenarbeit mit den lokalen Autoritäten sowie die Repräsentanten der unterschiedlichen religiösen und sonstigen Interessen-Gruppen sinnvoll. Individuums-zentrierte westliche Psychotherapie scheint nicht selten in Regionen ungeeignet, welche sich durch eine auf der Gemeinschaft basierenden Kultur auszeichnen. Die Wiederherstellung einiger der wichtigsten psychischen Schutzfaktoren (Integration in eine Familie oder eine Gruppe, Arbeit, Glaubenssystem etc.) sind die Grundvoraussetzung für psychische Gesundheit. Gesundheitserziehung ist notwendig, gleichzeitig sollte Wert auf die Ausbildung lokaler Laienhelfer gelegt werden, da diese durch ihre Nähe zur indigenen Kultur das Vertrauen der Bevölkerung genießen.

Schlagwörter Gesundheitssystem – psychische Gesundheit – Psychiatrie – indigene Kultur – Entwicklungsland – Gesundheitserziehung

Introduction: What Mental Health?

Some experts consider mental health as a continuum[1]. Thus, an individual's mental health may have many different possible values. Mental health is generally viewed as something positive. The definition of mental health includes emotional well being, the capacity to live a full and creative life and the flexibility to deal with life's inevitable challenges.

In 1993 the World Bank provided estimates of disease burden using the disability-adjusted life year (DALY), combining the years of life lost through premature mortality (YLL) and years lived with disability, weighted by the severity of the disability (YLD). A revised set of estimates was published as part for the first Global Burden of Disease (GBD) study in 1996, measuring the leading causes of disability (by

* This paper represents a revised version of a presentation given on the annual congress of the German Society for Tropical Medicine, 6–7. November 2009, at Munich, titled: Mental health in the developing world: Considering local human resources.

estimating lost years of healthy life). (Murray & Lopez 1996).

Mental disorders and drug use disorders were shown to be major contributors to population disease burden: In developed countries, the ten leading causes of lost years of healthy life at ages 15–44 were: (1) *Major Depressive Disorder*, (2) *Alcohol Use*, (3) Road Traffic Accidents, (4) *Schizophrenia*, (5) *Self-Inflicted Injuries*, (6) *Bipolar Disorder*, (7) *Drug Use*, (8) *Obsessive-Compulsive Disorders*, (9) Osteoarthritis, (10) *Violence*: 8 of 10 disorders are related to mental health.

Example depression:

Depression is an important public-health problem and one of the leading causes of disease burden worldwide. Depression is often co-morbid with other chronic diseases and can worsen their associated health outcomes. In a WHO World Health Survey (WHS) of 2007, adults aged 18 years from 60 countries in all regions of the world were studied (n = 245404). Overall, the 1-year prevalence for depressive episodes (according ICD-10) alone was 3,2% (95% CI 3.0–3.5). Further, between 9.3% and 23.0% of participants with one or more chronic physical diseases such as angina, arthritis, asthma or diabetes had co-morbid depression. The prevalence of co-morbid depression was significantly higher than that of depression in the absence of a chronic physical disease ($p<0.0001$). After adjustment for socioeconomic factors and health conditions, depression had the largest effect on worsening mean health scores compared with other chronic conditions. Consistently across countries and different demographic characteristics, respondents with comorbid depression had the worst health scores of all disease states (Moussavi *et al*. 2007).

High risk groups

Generally everyone can develop mental disorders. Specific high risk groups include peasants with insufficient access to mental health services, refugees, indigenous people, and migrants subjected to social disintegration and spiritual alienation. Failing to cope positively with these specific life conditions result in relatively high rates of mental morbidity, including mental retardation, depression and anxiety, suicide and substance abuse (Swan & Raphael 1995).

Refugees:

Refugees are vulnerable for developing mental health problems for a variety of reasons including traumatic experiences in their country of origin or escape from it, difficult camp or transit experiences, cultural conflicts, and adjustment problems in the country of resettlement, as well as loss of family members, their homes, and way of life in general. It is useful to consider the major psychosocial systems that are affected by the refugee experience, both within the individual and across the community as a whole. Suggested is the following simplified framework in which five fundamental systems are threatened or disrupted (Jablensky *et al*. 1994; Kaiser & Benner 2003):

- The attachment system: many refugees are affected by traumatic losses and separations from close attachment figures.
- The security system: it is common for refugees to have witnessed or encountered successive threats to the physical safety and security of themselves and those close to them.
- The identity/role system: the refugee experience poses a major threat to the sense of identity of the individual and the group as a whole. Loss of land, possessions, and professions deprive individuals of a sense of purpose and status in society.
- The human rights system: almost all refugees have been confronted with major challenges to their human rights. These include arbitrary and unjust treatment, persecution, brutality, and, in some instances, torture.
- The existential-meaning system: the refugee experience poses a major threat to the sense of coherence and meaning that stable civilian life usually provides for most communities.

Indigenous people:

There are estimations that around 5000–6000 distinct groups of indigenous people living in more than 70 countries of the world, in total at least 250 million people persons (Cohen 1999). These people often are considered as “victims of progress” (Bodley 1988), with all its implications of inequality, injustice and challenges to and repression of culture. Migration itself can create marginality, as can be found in African and Middle Eastern immigrants to Europe or south-east Asians and people from Central America journeying to the United States in search of a future in political and economical stability. Indigenous groups exhibit even higher rates of alcoholism, depression, anxiety and suicide than the “normal” population in developing countries.

Migrants:

Worldwide the proportion of people living in urban areas has risen from 30% in 1950 to 47% in 2000, and is estimated to have reached 57% in 2010. In developing countries the percentage is 37 % (in industrialized countries more than 70% in 2000), counting for approximately 1,4 billion human beings; by 2025 this proportion will probably reach 57%. (KRAAS 2007; BORK *et al*. 2009). The dynamic of migrants into urban areas makes it difficult to provide adequate health services. There is a class system comprising private high end health care and an often insufficient community-based, public sector. Urged to adapt to a new social environment, migrants facing an unknown situation per se are not familiar with local service structures (KRÄMER 2006). These factors contribute to a higher incidence of mental disorders with unsatisfactory access and utilization of mental health services. Further, there is a paucity of data impeding further analysis and trend observations on migrants' mental health and related services.

Mental health service indicators

The rates for numbers of psychiatrists are indicative of the huge differences in mental health care —they vary more than 10-fold across the European Region, ranging from 30 per 100,000 population in Switzerland and 26 in Finland, to 3 in Albania and 1 in Turkey. The median rate of psychiatrists per 100,000 population in the 41 countries that provided information is 9 (WHO 2008). In most of the developing countries in sub-Saharan Africa and south and south-east Asia, less than one psychiatrist per 100,000 population is found (WHO 2006a).

Example Myanmar, part I:

The population of Myanmar in 2005–2006 is estimated at 55.4 million, with a growth rate of 2.0 percent. About 70% of population reside in the rural areas; nationwide, the population density ranges from 390 per square kilometres in Yangon Division, (encompassing the city of Yangon), to 10 per square kilometres in Chin State, the western part of the country. The density of psychiatric beds in or around the largest city is 10.8 times greater than the density of beds in the entire country, implying impeding access for rural users. The total number of human resources working in mental health facilities or private practice is 265, at a rate of 0.477 per 100,000 general population, the number of psychiatrists is 89 (0,16 per 100,000 general population). The density of psychiatrists in or around the largest city is 4.17 times greater than the density of psychiatrists in the entire country. The density of nurses is 1.74 times greater in the largest city than the entire country. The number of professionals graduated last year in academic and educational institutions per 100,000 is 0.736. These are as follows: 4 psychiatrists (0.007 per 100,000 general population), 222 other medical doctors (not specialized in psychiatry) (0.4 per 100,000 general population). Based on best estimates, 1–20% of psychiatrists immigrate to other countries within five years of completion of their training (WHO 2006b). One percent of the training for medical doctors is devoted to mental health, in comparison to 13% for nurses and 0.28% for non-doctor/non-nurse primary health care workers (WHO 2006b).

Psychopathology: Speaking different languages

Physicians, including psychiatrists, and other health professionals and researchers, generally agree that an mental illness is likely present when a defined pathology can be found in brain tissue. Illnesses that directly arise in connection with such pathology are often neurological in nature; Parkinson's and Alzheimer's disease are two examples. When no known identifiable organic or physical pathology is present, as it is often the case in patients diagnosed with depression, mania, neurosis, and other mental disorders, the question arises as to whether it is correct to attribute the very real symptoms to scientifically defined causes, i.e. a specific pathology. To a degree, certain indicators, such as reduced thyroid function, support the medical hypotheses of chemical imbalance. One can define and attribute mental disorders to "chemical imbalances" which function as "weak points", for which neuropsychiatric drugs are now widely prescribed. Traumatic events such as war, displacement, loss of loved ones (negative life events) and other stressful events can trigger this predisposition (or "weak points") for mental disorders like psychosis (schizophrenia or major depression or mania) or can cause milder forms of mental disorder (without psychotic symptoms) like minor depression, anxiety, etc..

But: *"the depressive syndrome represents a small fraction of the entire field of depressive phenomena. It is a cultural category constructed by psychiatrists in the West to yield a homogeneous group of patients."* (KLEINMAN 1977: 3). So-called "culture-bound" syndromes like *latah* and *amok* in Malaysia, *susto* in

Mexico, *windigo* in the Indians of northern Canada, often mask underlying and universal disorders, in the sense that the "superficial" expression of behaviour is a result of the impact of the specific cultural background, but the underlying cause often is universal (HELMAN 1984). According to Kleinman, it would be more useful to consider these syndromes as "idioms of distress", as ways in which cultures designate how individuals and groups can communicate psychiatric distress (KLEINMAN 1988, KAISER & HLADIK 1998). As an example: Manson and colleagues found that among the Hopi Indians in the American Southwest few (7%) of the interviewed locals knew of a Hopi word or phrase that was an equivalent of the term "depression", nevertheless 50% of the clinical sample could be diagnosed with major and chronic depression (according the western classification system DSM) (MANSON *et al*. 1985). Mental health has to be considered as being deeply interwoven with economic and political concerns, such as poverty, hunger and malnutrition, violence, social change and dislocation (DESJARLAIS *et al*. 1995). Needless to say, mental health mirrors to a large extend "healthy" social (and environmental) conditions.

Example Myanmar, part II:

The help seeking behaviour of Burmese patients—typical for many regions in Asia—may be influenced by cultural-determined factors (such as difficulties in describing to a doctor close relationships), various folk beliefs, and the fact that patients commonly use somatic symptoms to communicate their feelings of depression or anxiety. Although Buddhism has a tremendous impact on the way of life in general, the Burmese (as well as Thai) patient's perception of mental illness is much influenced by the pre-existing and parallel-existing supernatural beliefs related to a number of cults such as the worship of "Nats" (spirits), astrology, and the practice of alchemy. Often traditional healers are consulted; their treatment usually involves a process of overcoming malevolent spirits and other intervening forces. Disregarding the differences between the criteria and methods for assessing psychopathology used by traditional healers, some behaviour may be considered pathological by both medical cultural systems—the indigenous as well as the western psychiatric. In the traditional system, "Nat" possession frequently is not regarded as a psychopathological condition, nevertheless it makes an exorcism necessary. Exorcists are widely used to expel harmful supernatural beings from the bodies of their victims with the assistance of benevolent beings. If the exorcism is followed by a return to "normal" behaviour, the ceremony is assumed to have been successful.

One reason that general practitioners are hesitant to treat patients with mental disorders is the dominant role of traditional healers (KENT 1996, WAY 1996).

Although western psychoanalytic psychotherapy is unknown in traditional Burmese society, Buddhist monks to this day function as providers of supportive psychotherapy, both in meditation centres and in monastic settings. Buddhism recognises many types of mind and personality; Buddhist psychology recognizes the negative consequences of attachment, ignorance, passion and immorality. The main approach in Buddhist psychotherapy is via insight – cognition.

"Mind is the forerunner of all mental states and the four aggregates of existence. Mind is their principal component. It is only through mind that fulfilment can be realised. The consequences of evil dispositions that one may bear by words or action shall be that the person concerned will experience incessant suffering even as cart-whells drawn by bullocks will perpetually follow in the path of their footsteps" (BUDDHIST PUBLICATION SOCIETY 1985 Dhammapada [Buddha's teachings]).

Ignoring philosophical presumptions, similarities to the cognitive behavioural psychotherapy can be observed.

One can conclude that mental health service indicators should take note of the existence of indigenous mental health services.

These indigenous efforts certainly are insufficient. The majority of cases of anxiety, panic disorders as well as depression remain untreated by western psychiatric standards; mental health hospitals and psychiatric ward at general hospitals often are overcrowded by patients with severe psychosis, including secondary psychosis due to cerebral malaria (WAY 1996). The apparent disinterest of many major global health agencies towards mental disorders is hindering improvement in developing countries' mental health services. Undoubtedly, there has been an increased acknowledgement of mental health in recent years; still, most global health initiatives continue to relegate mental disorders to the shadows (PATEL 2008).

The subject of mental health is human behaviour. Ultimately doctors'/medics' task is to answer the question: "Does this patient suffer; psychiatrists have

to ask: “Is this behaviour normal?” This question lies at the heart of cross-cultural psychiatry, which must determine normality in its cultural context.

Matti Joensuu, former Secretary of the Department of Cooperation of Men and Women in Church, Family, and Society of the World Council of Churches stressed already in 1967, that *“one very difficult problem in international work is the lack of deep understanding of cultural differences. Family life in Africa or Asia is very different from what it is in the West. If Western specialists, however well trained and clever they may be, go to the other continents and give family education, there is a big danger that they may advocate Western ideas with all there mistakes. Their teaching is not well received, because it is not relevant and helpful in quite different circumstances”.* (JOENSUU in CLINEBELL 1970, cit. chapter 35).

In 2001 approaches to a better integration of mental health services into the general health sectors had been named. Examples are using the schools for promoting mental health, integration of mental health services within the Primary Health Care System, inventing urban based programmes like the Healthy City projects. Further the introduction of psychiatric wards in general hospitals or the replacement of large hospital for mental disorders with community mental health centres have to be mentioned (MOHIT 2001).

The main outcome goal for therapy is increased functionality to achieve personal goals, rather than symptom reduction. However, symptom reduction may also be a goal, particularly for high levels of symptoms of Post-Traumatic Stress Disorders (PTSD), major depression, or other disorders that respond to medication. These disorders require a combination of medical, psychological, social, and legal intervention. In order for mental health care to be effective, it is essential that primary health care serve as the main health service infrastructure. The challenge is to orientate and train primary health care workers in mental health skills and services, including diagnosis and therapy.

Mental health services should be closely coordinated with general health services, psychosocial services, and other relevant rehabilitation, social, educational, occupational, cultural, and recreational activities.

They also should be community based, and, wherever possible, focus on early intervention at the primary and later at the secondary and tertiary levels of prevention (PATEL 2002).

Other points to consider include:

- In general any approach in providing a mental health service should be discussed with the health and political committees as well as representatives of the different religious groups, raising awareness of mental disorders and tolerance towards social minorities like homosexuals.
- Individual-centred western psychotherapy and especially psychoanalysis may be not the right approach to help people in developing countries because of their community-based culture
- The training of local non-specialist health workers should be mandatory, as they are regarded as people with the same cultural background
- To deal with mental health in some cultures still is a taboo, due to the widespread opinion that having mental difficulties means one is insane or not able to cope with one’s problems of daily life.
- While being concerned with mental health it should not be forgotten that people’s reaction people in certain situations are considered normal in specific cultural environments.

Too often, medical anthropologists and sociologists accuse psychiatrists of transforming social problems into medical conditions. Yet social scientists who place illness entirely in the social realm deny the personal dimension, the personal experience of suffering (KLEINMAN & KLEINMAN 1991). Confessing that there are improvements in these areas, still the problem of acceptance of all of these approaches by the local population is unsolved. Only a comprehensive approach in psychiatry—with includes bio-psycho-social as well as historical, mythological and spiritual aspects can increase mutual understanding.

Conclusion

Main mental health problems in developing countries are: Alcoholism, domestic violence, depression and adjustment disorders, suicidal ideation. The following shortcomings can be named: an insufficient number of mental health specialists in rural regions and under-developed city areas as well as no-specialist-(mental) health-workers, further a lack of community health centres and psychiatric wards in general hospitals.

A deficit in awareness concerning the diagnosis of mental disorders partially due to a lack of knowledge of prophylaxis and treatment of mental disorders has to be overcome by involving local authorities such as healers, politicians, and religious leaders[2]. Health consultants should consider not just mortality statis-

tics but also morbidity estimates. The Global Burden of Disease (GBD) focus is a good measure method to start with.

Notes

(1) In medicine a "disease" is more or less clearly defined. Because sometimes it is difficult to make a clear cut between *still mental healthy* and *already mental ill*, the WHO recommends the use of the term "disorder" (i.e. something is not in order) instead of "disease". Irrespectively of that, being "suicidal" for example is not a disease.

(2) The struggle of Rüdiger Nehberg against the female circumcision became successful when he started to include the local as well as national Islamic leaders in his programs (Nehberg & Weber 2008).

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