An Introduction to Global Health and Global Health Ethics: Mental Health and the Cultural Context of Global Health

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Learning Objectives:

1. Describe what defines culture at the population level and at the individual level
2. Assess the cultural components of mental illness
3. Compare the concepts of cultural competence and cultural humility in the setting of global health

Culture in Global Health

Culture is a complicated concept that has important implications in global health. Take a moment and consider your own culture. What comes to mind? Where your ancestors came from? The country you live in now? Culture is a term that can change definitions depending on the context. Below are two definitions that serve as a starting point for understanding what "culture" is. In concrete terms culture, "encompasses social history over generations, rituals, beliefs and material artifacts."[i] While this version points out the visible aspects of a culture at the population level, it does not address what culture can mean at the individual level. The Association of American Medical Colleges (AAMC) defines cultural identity as being based on, "heritage as well as circumstances and personal choice, but may be affected by race, ethnicity, age, language, country of origin, acculturation, sexual orientation, gender, socioeconomic status, religious/spiritual beliefs, physical abilities and occupation."[ii] The differences between these two views reveal an interesting dichotomy in culture. At the population level, culture is a term that groups people together and it is defined by what is the same, but at the individual level, culture can be about the uniqueness of identity based on all the different groups we belong to.

The field of global health encounters culture at both the population and individual level as it seeks to expand access to health care. In order to be successful, groups like the World Health Organization (WHO) must take into account the cultural context of the disease or condition they are trying to address. To that end, here is a third concept of culture: "culture is to society what memory is to the individual" (Kuckhohn & Kroeber, 1952). Culture here is defined more by its use then its content. In this view culture is a medium of communication for how people experience and respond to the world.[iii] In this way, the rituals and artifacts of a culture can provide a common meaning and give guidance about how to interpret new experiences. This concept can be especially helpful when looking at issues within healthcare.

Cultural Concepts of Illness

Think for a moment the times when you have started to fall ill. Maybe you were "fighting off a cold" or just woke up not feeling like your usual self. That experience of losing health is not defined by the diagnostic test you might undergo to find out what is wrong or the treatment that makes you feel better. That experience is an individual phenomenon and how we interpret them has a lot to do with our culture. Medical anthropologists have studied beliefs about health across the globe and have identified some common categories of what people believe causes disease.[iv]

Natural Causation: Illness is an episodic, individualized loss of health due to an unseen, natural agent, such as genes, viruses, bacteria or stress. For example, the common cold is the result of a *rhinovirus* infection.

Mystical Causation: Illness is caused by an act or experience of the individual, such as fate, contagion, or mystical retribution. It is the act or experience which brings on the illness. For

example, attributing illness to astrological alignment or the violation of social taboos such as coming in contact with a menstruating woman.

Animistic Causation: Illness is caused by a personalized supernatural being. This encompasses beliefs such as bad spirits causing illness or the idea of "soul loss". Another example would be seeing cancer as being "God's will".

Magical Causation: Illness is caused by a person or persons using magic. An example is the "evil eye" or one person causing illness to another by casting a jealous glance.

Example of a Nazar amulet. These are common in countries such as Turkey, Greece, Egypt, Israel and Iran to ward off the evil eye.

There are several important things to keep in mind with the above categorizations. First, while the "natural causation" view is popular in the Euro-American tradition, it is not the most popular view throughout the world. Second, beliefs about mystical, animistic or magical causes are common in industrialized nations as well as in the developing world. This is in part because, third, most people hold more than one belief about what causes ill health.[v] This pluralism is evident in the cancer patient who takes chemotherapy, while asking friends to pray for a cure.

The pluralism evident in peoples' understanding of what causes illness extends to interpretation of treatments and the role of healthcare providers. The cultural context of a disease can have a great impact on how individuals are diagnosed and treated. Perhaps, nowhere is this more evident than in the field of mental health.

Global Mental Health

Mental Health encompasses a number of different conditions including psychosis (schizophrenia, delusional disorders), mood disorders (depression, bipolar), anxiety disorders, dementia and substance abuse (alcohol, and other drugs).[vi] It is estimated that over 400 million people in the world live with mental illness and less than half receive needed care.[vii] In the WHO 2004 report on the Global Burden of Disease, mental health conditions made up 7.4% of DALYs (disability-adjusted life year), a measurement that accounts for the disability or premature death caused by a condition. In that report major depression was the number one cause of DALYs in high- and middle-income countries and the 8th leading cause of DALYs in low-income countries.[viii]

However, these aggregated numbers can be misleading as to the variability in mental health throughout the word. In 1990s the WHO developed the Composite International Diagnostic Interview (CIDI) as a means to identify mental health conditions in communities throughout the world. Questions in the CIDI are designed to pick up on symptoms of mental conditions such as anxiety, depression, suicide attempts, and substance abuse – as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). As of 2010, 150,000 people in

28 countries were interviewed, and the results showed a high degree of variability in the prevalence and treatment of mental disorders. For example, the overall prevalence of persons living with at least one mental condition varied from < 8%, in Japan, Nigeria, and the Shanghai district of China, to greater than 25%, in the US and Sao Paulo, Brazil.[ix] This wide variability, in many ways, is related to the complicated interaction between mental illness and culture.

Stigma: One reason for the low prevalence of mental health conditions in some countries may be the fundamental invisibility caused by the stigma associated with mental disorders. Throughout the world, persons suffering from psychosis, intellectual impairment, and other mental conditions are marginalized and prevented from fully participating in society. This may be more pronounced in low- and middle-income countries where the lack of effect treatment and support can lead to imprisonment and dehumanization of the mentally ill.[x] Stigma can also affect the policy-making decisions at the level of governments and international aid. People tend to separate mental health from other areas of medicine, which can lead to the exclusion of mental health in global health priorities.[xi]

Social Determinants: The complex relationship of mental health and environment can lead to an over-emphasis on addressing the social determinants of mental illness, rather than addressing the disease itself.[xii] Take for example the incidence of post-traumatic stress disorder (PTSD) in areas of conflicts. While efforts to address the outcomes of conflict can include resettlement, medical care and direct aid, they do not always include consideration for resulting mental illness. Many individuals with chronic diseases, such as tuberculosis and HIV also suffer from mental illness, but efforts to relieve their suffering do not always count or consider the additional burden of mental illness.

Westernization: Another reason that surveys may result in vast discrepancies is the use of the DSM as the basis of diagnosis. The DSM is a tool developed and used mostly in the countries of Europe and North America and defines the symptoms of mental health conditions within that culture.[xiii] So what happens when other cultures either have different types of conditions or different presentations? Take for example, "brain fatigue" – a syndrome that is known in several African cultures to affect students, mostly from rural backgrounds. Symptoms include "headaches, crawling sensations in the brain, [and] blurred vision" which can cause significant disability. This could be a different manifestation of depression or anxiety or, it may constitute a completely separate mental condition.[xiv] The point is, that using a tool like the DSM to diagnose and measure mental illness can fail to include cases of either culture-specific symptoms or culture-specific diseases.

Medicalization: On the other hand, the high prevalence of mental illness in places like the United States may be indicative of a paradox within mental health. While some countries marginalize and deny mental illness, others treat normal pain and suffering as a medical disorder.[xv] This can lead to the difficulty of trying to increase access to treatment in some

countries, while at the same time trying to reduce use of pharmaceuticals in other parts of the world.

These are just some examples of how culture can affect the diagnosis and treatment of mental health. Cultural context is an important part measuring health and delivering healthcare, not just mental health, and addressing these issues will be important as efforts to address the burden of mental illness move forward.

Cross-Culture Encounters: Two Approaches[xvi]

As discussed earlier, culture can be understood as a lens through which an individual interprets and explains their experiences. In an encounter between two different cultures it can be difficult to communicate due to fundamental differences in language, custom and beliefs. Below are two approaches towards improving the communication between individuals from different cultures.

Cultural Competency: An idea that has gained ground in US healthcare since the 1980s, cultural competency refers to developing the awareness and knowledge of other cultures in order to better respond to cultural differences. An example is a physician taking the time to become familiar with popular expressions of symptoms and illness in different cultures; "swimmy-headed" = dizziness, "attack of the nerves" = anxiety or depression.

- *Pros*: This approach has the benefit of being based in concrete knowledge that allows for easy incorporation into medical training.
- *Cons*: This approach tends to favor oversimplification, or stereotyping of individuals based on their background. In addition, it can emphasize cultural differences between providers and patients, which can diminish solidarity.

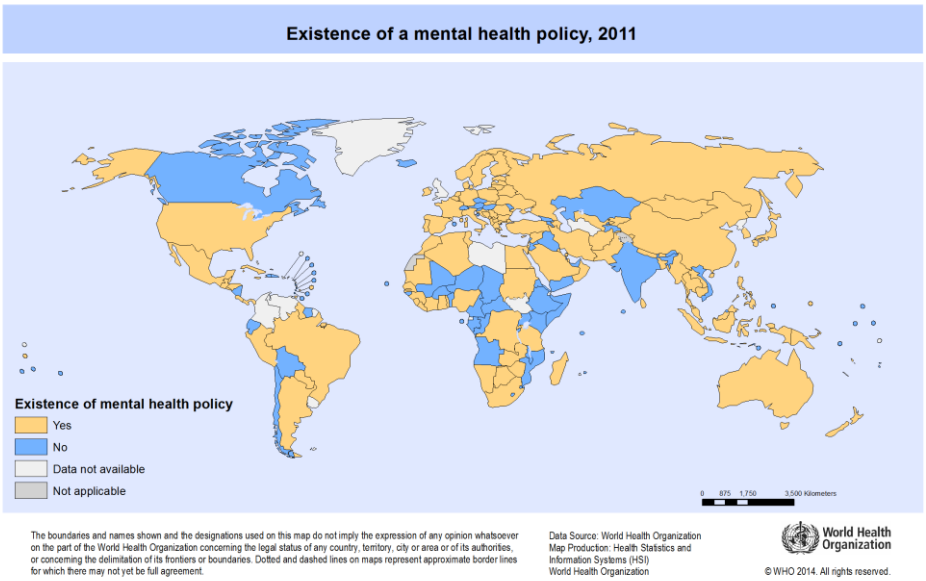
Cultural Humility: Humility, or the virtue of being humble, is about "having knowledge of one's own deficiency" (Aquinas). Within cultural encounters it refers to providers recognizing their own cultural biases and avoiding arrogance. An example might be a physician who takes a moment to consider their own bias in treating individuals who abuse IV drugs in order to prevent themselves from stereotyping a new patient in the emergency room.

- *Pros*: As humility begins with the provider, this approach is adaptable to each cultural encounter and fosters respect and openness to cultural exchange.
- *Cons*: It is a more ambiguous concept that makes developing cultural humility in medical training more difficult. It takes time and a commitment to self-reflection.

In practice, it is usually a combination of both approaches that can be most effective. While self-awareness is important for good communication, knowledge about other cultures is an important component.

Future Directions

It has only been in the past few decades that mental health has become part of the discussion in global health. The WHO's Mental Health Surveys and Global Burden of Disease Report (2008) have demonstrated the significant disability that comes with mental illness. However, when combined with neurological conditions, such as epilepsy, neuro-psychological disorders make up 11.5% of DALYs but account for only 3.8% of healthcare expenditures.[xvii]



Research: Addressing questions about the validity of surveys and treatments across cultures will require more research on mental health within developing countries. A 2001 analysis of international mental health journals revealed that 90% of all literature is derived from Western societies.[xviii] A better understanding of cultural differences in mental illness through research in low- and middle-income countries will allow for the development of culture-specific interventions.

Awareness: Traditionally, development efforts have tried to focus on vulnerable populations, such as women, children and the poor. Certainly, in many countries, the mentally ill are stigmatized and marginalized and represent a very vulnerable population.[xix] Increasing awareness of the burden of mental illness will aid efforts to prioritize mental health in the global health agenda.

Cultural Differences in Treatment

The story of mental illness in global health illustrates how cultural context can influence how disease are recognized and experienced in different cultures. In addition to having different explanations of what causes disease, cultures across the world have different methods of treating disease and illness. When global health interventions, based in Western medicine, are brought

different areas of the world health beliefs can conflict. Consider the following case from Anji Wall's, *Ethics for International Medicine: A Practical Guide for Aid Workers in Developing Countries* (2012):

Case 1.4: Sorcery and Tuberculosis

> A twenty-three-year-old man presents to a clinic in rural Haiti with a history of weight loss, fevers, night sweats, and a cough productive of bloody sputum. He has gotten so weak that he is unable to work in his fields. The medical aid worker clinically diagnoses him with tuberculosis and collects a sputum sample to send to the lab for confirmation and resistance testing. When the man is told that he has tuberculosis, he says that he is sure that his neighbor gave it to him through a curse.
>
> The medical aid work explains to the man that there are medications available to treat tuberculosis, but they have to be taken every day for nine months in order to be effective. The clinic will provide him with these medications free of charge. The man agrees to take the medications but comments that what he really needs is for his neighbor to reverse the curse. The medical aid worker wonders whether it is appropriate to initiate this intense treatment regimen, given that the man does not understand the etiology of his disease or the purpose of treatment, and if so, whether he should try to change the patient's beliefs regarding the etiology of his condition.

In this case, an individual from the Western tradition encounters a very different view on what causes illness.

Does the man have to understand the etiology of tuberculosis in order to receive treatment?

Is it appropriate for the medical aid worker to try and change the patient's beliefs?

How would the concept of cultural competence apply in this situation? How would the concept of cultural humility apply in this situation?

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[i] Yvonne M Johnson and Shari Munch, "Fundamental Contradictions in Cultural Competence.," *The Social Worker* 54 (2009): 220–31, doi:10.1093/sw/54.3.220.

[ii] David Cowan, "Cultural Competence: Definition, Delivery and Evaluation," *Ethnicity and Inequalities in Health and Social Care* 2 (2009): 27–38, doi:10.1108/17570980200900027.

[iii] Malcolm MacLachlan, *Culture and Health: A Critical Perspective Towards Global Health* (Hoboken, NJ: Wiley, 2006).

[iv] Ibid.

[v] Ibid.

[vi] Vikram Patel, "Why Mental Health Matters to Global Health.," *Transcultural Psychiatry* 51, no. 6 (2014): 777–89, doi:10.1177/1363461514524473.

[vii] Becker et al., "The Unique Challenges of Mental Health and MDRTB: Critical Perspectives on Metrics of Disease."

[viii] The World Health Organization, "Burden of Disease : DALYs."

[ix] Jordi Alonso et al., "Global Mental Health: The World Mental Health Surveys Perspective," in *Understanding Global Health*, ed. W H Markle, M A Fisher, and R A Smego Jr, 2nd ed. (New York: McGraw-Hill, 2010).

[x] Arthur Kleinman, "Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years," in *Medical Anthropology at the Intersections: Histories, Activism and Futures*, ed. Marcia C Inborn and Emily A Wentzell (Durham: Duke University Press, 2012); Becker et al., "The Unique Challenges of Mental Health and MDRTB: Critical Perspectives on Metrics of Disease."

[xi] Michelle Funk et al., *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* (Geneva: WHO Press, 2010).; Anne E Becker and Arthur Kleinman, "Mental Health and the Global Agenda," *The New England Journal of Medicine* 369 (2013): 66–73, doi:10.1056/NEJMra1110827.

[xii] Patel, "Why Mental Health Matters to Global Health."

[xiii] Becker et al., "The Unique Challenges of Mental Health and MDRTB: Critical Perspectives on Metrics of Disease."

[xiv] MacLachlan, *Culture and Health: A Critical Perspective Towards Global Health*.

[xv] Kleinman, "Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years."

[xvi] Cowan, "Cultural Competence: Definition, Delivery and Evaluation"; Johnson and Munch, "Fundamental Contradictions in Cultural Competence."; Rebecca J. Hester, "The Promise and Paradox of Cultural Competence," *HEC Forum* 24, no. October (2012): 279–91, doi:10.1007/s10730-012-9200-2; Jack Coulehan, "'A Gentle and Humane Temper': Humility in Medicine.," *Perspectives in Biology and Medicine* 54, no. 2 (2011): 206–16, doi:10.1353/pbm.2011.0017.

[xvii] Becker et al., "The Unique Challenges of Mental Health and MDRTB: Critical Perspectives on Metrics of Disease."

[xviii] Ibid.

[xix] Funk et al., *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group*.