The lessons I learned as a psychiatrist from my transcultural work in low- and middle-income countries

Julian Leff

Institute of Psychiatry, London, UK. Email: julianpleff@gmail.com

Conflicts of interest: None.

doi:10.1192/bjp.2017.35

© The Author 2018. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

Transcultural observations offer an opportunity to study attitude to mental illness in different societies and family structures. The disparity between industrialised and lower-income societies reflects greater tolerance due to the ability of extended families to compensate for the patient’s limitations.

My early work in London with families of people with schizophrenia was enriched by participation in the World Health Organization International Pilot Study of Schizophrenia (WHO IPSS), conducted in nine low- and middle-income countries. This gave me the opportunity to study the way in which families cope with mental illness in different societies and family structures.

Even in low-income societies, differences emerged between rural and urban domains. The territory of Chandigarh in India offers a good example of this. In an agrarian area, the villagers live in extended families. But Chandigarh city, which has one of the highest per capita incomes in India, was designed by Le Corbusier to reflect a Western lifestyle, and residents live in nuclear family households. Patients in the surrounding countryside were found to do better owing to their inclusion in the community and participation in simple tasks, such as herding goats; in contrast, those in the city faced higher expectations and greater disappointment. Nonetheless, in urban environments too, support of the extended family and greater acceptance provides patients in lower-income societies with better conditions than those living on their own or in sheltered accommodation in higher-income societies.

For instance, in Varanasi, India, I was introduced to a family, which consisted of five sons who ran the family business in a multi-storey house. The bottom floor of the house was occupied exclusively by the men, while the many women and children were confined to the top floor. One of the brothers had schizophrenia. Every morning, all the men went down to the Ganges for a ritual bath. The young man with schizophrenia was always included among the brothers and they looked after him in a very caring way. He did not take part in the family business but otherwise lived an ordinary life among his family, which enabled him to feel that he really belonged even though he was not contributing economically.

This disparity between industrialised societies and lower-income areas reflects an attitude of caring acceptance regardless of disabilities. The indubitable importance of the family in contributing to better outcomes for people with schizophrenia is evidenced by the 5-year follow up of the WHO IPSS patients across different countries (Leff et al., 1992). The lower relapse rate for patients living with their families in lower-income societies, even when medication is unobtainable, is attributable to the supportive management of the illness by the relatives, their understanding of the patient’s incapacities and lower expectations of her/his contribution to the family’s wellbeing.

Traditional healing

In keeping with beliefs in low- and middle-income countries, people who are experiencing any kind of illness usually initially choose indigenous expertise over Western medicine (Leff, 1988). While undoubtedly charlatans exist, the strategies of traditional healers should not be scoffed at. They share the same ideology as their clients, who consist of not an isolated patient but the entire family or even clan. Whereas Western consultations tend to be private, confidential between the patient and doctor, traditional examinations take place with all relevant family members present. The best healers are very attuned to the cultural background of their clients and can ‘divide’ interpersonal relationships that are disguised as bodily complaints. For instance, a healer I encountered in Nigeria told me that if a man came to him with erectile problems, he would say suggestively, ‘Here’s the medicine, drink it daily and whatever you do stay away from your sister-in-law!’ This tantalising injunction, referring to a local sexual taboo, is evidence of a psychologically astute understanding of erotic dynamics.

Much mental illness is ascribed to witchcraft, ancestral spirits or possession by harmful demons. Various local remedies and practices are used to engage with these, to placate or extract them. However, most healers I interviewed (through interpreters) distinguished between illnesses originating in local understandings and those necessitating Western medicine. For example, a healer I interviewed in Agra, India, told me that if a patient continued to be miserable despite indigenous treatments he would be sent for electroconvulsive therapy at the local hospital (where the family camped out in the grounds to provide...
meals and support for their ill relative). This shows that families are usually quite willing to accept a pragmatic composite of traditional and modern treatments. This flexible approach is more sophisticated than that of the Western-educated then-president of South Africa, who banned antiretroviral drugs in hospitals and advocated African onions as a cure for AIDS.

Similarly, a patient I saw in Ethiopia was brought in a catatonic state by his family, who had walked for many days from their far-off village. They said they had previously taken him to the Coptic church, where he was given holy water and beaten to exorcise the demon. When that did not seem to help, they put him in a cart and walked with him to Addis Ababa, to the one psychiatric hospital in the country, which serves 99 million people. Once given antipsychotic medication he rapidly recovered.

During my time in the IPSS, I was fortunate to see films and slides made by colleagues who had had access to indigenous ceremonies from many societies across the world. However weird some practices may seem, including trance states and exorcisms, they make sense in terms of local traditions, shared wisdom and beliefs about the source of illness and its extraction. For example, a film from Sri Lanka showed the exorcism of a demon which was held responsible for the illness of a woman in labour. The family of the patient called in a healer to perform this exorcism, which involved a very costly ritual of insistent drumming lasting from dawn to dusk. The patient was in fact suffering from pre-eclampsia. When the ceremony was completed to the satisfaction of the whole village, they took the patient to the local antenatal clinic, where she gave birth.

The family alone could not have afforded this ceremony, so their friends and neighbours contributed. This kind of solidarity is typical of many lower-income societies. Throughout Africa it is known as Ubuntu, meaning ‘togetherness’ or, as the locals put it, ‘I am because you are’. A sentiment we seem to have forgotten.

References