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ETHICS AND MENTAL HEALTH: AN INTERCULTURAL APPROACH

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Abstract: While the “Western” biomedical narrative led to great breakthroughs, it does not address adequately cultural expressions of certain pathologies and to adjust for cultural differences. This present article provides the moral reasons for adopting an alternative intercultural model of mental health against the colonizing tendencies of the “Western” biomedical narrative.

Introduction

Beginning in the late 1960s, the World Health Organization (WHO) had conducted three large international studies over the course of twenty-five years with regard to mental health in various countries (Watters, 2010, p. 137). These research findings showed that patients outside the United States and Europe had significantly lower relapse rates of mental health conditions; specifically, in India, Nigeria and Columbia, patients had longer periods of remission and higher levels of social functioning than patients in the United States, Denmark or Taiwan. In industrialized nations, forty percent of patients with schizophrenia were judged over the life course to be “severely impaired” while only twenty-four percent of patients in “poorer countries” were considered “severely impaired” (Ibid). The result of WHO’s findings presented a paradox for the medical community: how could it be that the regions of the world with the most resources to devote to mental illness, such as the best technology, cutting edge medicines, and contemporary research, had the most troubled and socially marginalized patients (Ibid, p. 138)?

Around the same time, anthropologist Juli McGruder (2004) had studied the families of individuals with schizophrenia in Zanzibar for over two decades. While the Zanzibar population is predominantly Muslim, the people often make use of Swahili spirit-possession beliefs to explain the actions of someone not conforming to social norms. This violation of social norms could be as mild as a sister lashing out at a brother, but also as extreme as an individual experiencing psychotic delusions. McGruder found that these beliefs served a useful function in mental health treatment: the beliefs provided a variety of socially accepted interventions and ministrations that kept the individual within the family and kinship group. Unlike the “Christian sense” of “casting out demons,” McGruder realized that the families would coax the spirits with “food and goods” or “song and dance.” These beliefs had, in turn, unexpected benefits for the individual living with schizophrenia: when the illness went into remission, the person could retake his or her responsibilities in the kinship group (McGruder, 2004; Watters, 2010, ch. 3).

McGruder’s research provided an interesting answer to this tension in WHO’s findings: rather than “curing schizophrenia,” McGruder determined that the spiritual beliefs of the families in Zanzibar maintained the individual’s status within one’s social group. Thus, this group cohesion enabled the individual to effectively manage the course of the illness. McGruder’s research prompts some interesting questions with regard to the moral foundation of global public health. Global public health draws its legitimacy from its direct role in promoting human flourishing, whether that role is understood in terms of promoting social goods, promoting benefits to individuals and their communities, or eliminating the barriers of poverty to equal treatment. While there is broad agreement to this sense of justice in the abstract, McGruder’s research points to the difficulty in effecting that justice in the concrete. In the particular case of mental health, a clinician must ask “am I being just to my client using this treatment?” The moral dimensions of this treatment may be understood to arise from a practitioner’s very familiar guiding principle: first, do no harm. The

harm principle, having originated in its modern form from John Stuart Mill's essay "On Liberty" (1869), assumes that individuals are generally in the best position to know what is in their own best interest, and not to respect their perspectives, is to do harm to their liberty. How to implement this core view, however, increasingly has been challenged in the case of mental health (Conly, 2014; Sunstein, 2013). On the one hand, most practitioners have adopted the primary "Western" model of mental health. This model assumes that the practitioner "knows best" and aims to cure the patient from disease using pharmacological drugs and the established practice of cognitive-behavioral therapy. This model sees the patient's perspective, relationships, social roles, and cultural beliefs as only secondary to treatment. On the other hand, in response to the dominant "Western" model, some practitioners have adopted either the cultural competency model or the holistic model when treating their patients. While both of these secondary models try to incorporate elements of "culture" and nature into the healing process, both have been guilty of adopting the view that the practitioner knows better than the patient. As a result, both risk maintaining the sorts of outcomes WHO found.

McGruder's research, moreover, illuminates the need for an overlooked alternative solution: the integrated model of mental health, which incorporates indigenous approaches to health promotion. This overlooked model explains and illuminates the features of mental health treatment not operative in standard ways of framing the debate over global healthcare. It illuminates the circumstances surrounding the families in Zanzibar. Furthermore, it offers wise guidance about effective efforts to prevent harmful practices and to endorse beneficial practices which enable human flourishing. The aim of this paper is to provide the moral reasons for adopting the integrated model of mental health in global healthcare. I do so by first providing an overview of the basic options of mental health, and then move on to describe the integrated model of care. I then characterize the moral issues at hand in each of these models, and finish with the consideration of whether we are morally obligated to adopt the integrated model.

The Basic Options

The notion that one can attribute the cause of one's mental distress to a source in the brain is a relatively new idea. Over the last fifty years, this new biomedical narrative has been adopted by mental health practitioners, and the resulting belief has been that if the disease is a "disease of the brain," then the individual with that condition "suffers from a broken brain" that must be fixed (Watters, 2010, pp. 172-3). As a result, this framework provides a proposed "solution" to each and every mental health "problem." It is this cognitive framework that provides the backdrop to the three most common options adopted by mental health practitioners: the "Western" model, the Cultural Competency model and the Holistic model. The fourth option, the integrated model, by contrast, does not incorporate this biomedical narrative.

Option 1: The "Western" Medical Model

Most people within the United States and Europe embrace the "Western" Medical Model of mental healthcare.¹ This model maintains the belief that there is a biological basis of psychic suffering. It is assumed that since there is a biological basis for suffering, this belief can be used to dispel prescientific myths and harmful stigma. Thus, the DSM-IV describes "real disorders of the mind" and recommends that practitioners should treat "mental illness" like a "brain disease" over which the patient has little choice or responsibility (Lustick, 2015). Specifically, Bracken et al. (2012) argue that this model of the mind commits itself to the following three assumptions:

¹ Not all "Western" countries embrace the "Western Model." For example, France is creating an alternative DSM 5 manual in psychiatry. Additionally, New Zealand's counseling services depart from the traditional services of the "Western Model." Please see Lane's article, "Anti-DSM Sentiment Rises in France" and Joyce's "Focus on Psychiatry in New Zealand," which discuss these alternatives in more depth.

- (a) Mental health problems arise from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual.
- (b) These mechanisms or processes can be modelled in causal terms. They are not context-dependent.
- (c) Technological interventions are instrumented and can be designed and studied independently of relationships and values (p. 430).

These assumptions provide a working picture of mental health that can be mapped and categorized with the “same causal logic used in the rest of medicine, and our interventions can be understood as a series of discrete treatments targeted at specific syndromes or symptoms” (Ibid).

Option 2: The “Cultural Competency” Model

Some healthcare practitioners have argued for a model that takes into account the socio-cultural factors of the patient such as personal identification, language, thoughts, communications, actions, customs, beliefs, and values often specific to ethnic, racial, religious, geographic or other social groups (NIH). Known as the “cultural competency” model, this model acknowledges that cultural factors are crucial to diagnosis, treatment, and care. Furthermore, the cultural competency model recognizes that cultural factors can shape a patient’s “health-related beliefs, behaviors, and values” (Kleinman & Benson, 2006, p. 1673). The overarching aim of the cultural competency model is to enable the healthcare provider to deliver “services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients” (NIH).

An example that illustrates the cultural competency framework is the “It all Starts at the Front Desk” list of procedures provided by the NIH National Center for Cultural Competence. In this list, providers are instructed to develop policies and procedures for their staff to follow such as when the staff encounters individuals

who speak little or no English, have low literacy level, or may be “hearing impaired” (NCC). Thus, the cultural competency model acknowledges the challenges presented by different communities and recognizes the cultural traits and health difficulties particular to each racial and ethnic community and linguistic group (NIH).

Option 3: The Holistic Model

The third option in mental health is the holistic model of health. Rather than focus on cultural-competency training, the holistic model incorporates spirituality and religion as essential components for the treatment of the individual diagnosed with the medical condition. Also known as the “biopsychosocial-spiritual model,” the National Center for Cultural Competency (NCC) notes that holistic model holds to three key components in treatment:

- (i) Holistic health aims to treat individuals not only by treating specific symptoms but also by promoting the overall health of individuals, families and communities.
- (ii) Holistic health “recognizes that for some individuals and families, the experience of illness and pain may relate to spiritual concerns and that those concerns may manifest as physical or emotional symptoms.”
- (iii) Holistic health emphasizes support and comfort for the individual and his or her family within the community.

The holistic model of health provides patients with opportunities to promote spiritual well-being as well as treating the “mind and body.” The holistic model, however, has yet to become widespread practice in the medical field.

Option 4: The Integrated Model

Most discussions of global mental healthcare, specifically with reference to “developing countries,” assume that the “Western” Model can be extended to indigenous groups. This assumption, however, has been shown to be false. Bodeker (2001) has observed that often one of four kinds of relationships between “modern” and “traditional” medicine develops in a region. The first relationship can be *monopolistic*, where “Western” medical doctors have the sole right and recognition from the government to practice. The second kind of relationship is *tolerant*. In this relationship, “traditional” medicine is allowed in practice, but it is not officially recognized or endorsed by the local or national government. The third relationship is *parallel* and offers a dual or plural system, in which separate components of the health system operate alongside each other. This relationship seems to be what has been adopted in South Africa, which allows the “Western” medical system, the allied health services (holistic), and African traditional healing (Lazarus, 2006, p. 534). The African traditional healing, however, has not yet been officially recognized by the government. The final relationship is *integrated*. This relationship differs from the holistic relation (Option 3) insofar as it integrates the local practices and customs of the individual with biochemistry, such as needed medications or surgery. This integration can occur at the levels of practice or education or both. For individuals “living in two worlds,” an integrated model of practice or health education may promote overall health and well-being more successfully than relationships of the other three kinds.

Unlike the other options, the integrated model promotes the existential dimension of our daily living. Sandy Lazarus (2006) has argued that the biomedical narrative mistakenly treats health as a condition unconnected from the historical, social, political and economic institutions which shape an individual’s everyday lived experience. A healthcare program that ignores these significant aspects is in danger of being unsuccessful in the long term. Moreover, Lazarus claims that treatment of mental health requires not only the neurobiological treatment of the individual, but also the proper understanding of the “indigenous knowledge,” social support

group and community surrounding that individual. To do this, Lazarus argues that we must understand an individual's *lived world*, which includes existentially meaningful aspects. Lazarus specifically defines *indigenous knowledge* as "knowledge that is held and used by a people who identify themselves as indigenous of a place based on a combination of cultural distinctiveness and prior territorial occupancy relative to a more recently arrived population with its own distinct and subsequently dominant culture" (2006, p. 524). This concept can be understood to describe locally relevant or community knowledge generated from peoples' experiences (Fasokun, Katahoire, & Oduaran, 2005). A patient's *worldview*, by contrast, describes the individual's perspective "through a combination of social, cultural, and individual histories and dynamics (Wilber, 2001; Lazarus, 2006, p. 524)."

While integrating indigenous knowledge into the practice of mental healthcare can be helpful, Lazarus cautions against generalizing indigenous knowledge across local contexts (2006, p. 528). The three other models have a tendency to overgeneralize certain frameworks whereas the integrated model has the ability to maintain respective differences. While many have contrasted indigenous knowledge systems against the "Western" model, Lazarus found that her work with indigenous groups often incorporated integrated approaches because these populations have had to learn to live and work in and with different worldviews (p. 530). This integrated approach to psychological and public health practice was first proposed as a "hybrid" approach by Duran and Duran (1995) and focused "particularly on the phenomenon of historical trauma in the Native American context" (as cited by Lazarus, 2006, p. 531). Duran and Duran argued that it is important for practitioners to understand "the colonial history, particularly the 'colonization of the life world' of Native Americans, and the severe spiritual and psychological injury (the soul wound) and intergenerational trauma that has occurred as a result" (Ibid). Furthermore, healing as an integrated response to historical trauma should include strategies that celebrate a logic of difference and diversity.

The Moral Implications

In moving to evaluate these models, we return to the basic moral question of global healthcare: am I being just to my client using this treatment? Stated more weakly, one might ask: do we commit acts of moral harm when we do not acknowledge the lived world of the patient? Relatedly, we may ask several interconnected questions: am I promoting the best health for my client using this treatment? Do we have obligations for governments to recognize integrated or parallel forms of health treatment? Are we obligated to establish training and educational programs for practitioners to enhance their knowledge of indigenous perspectives? Do we have obligations to provide treatment options that extend beyond the “Western” pharmacological basis? Although the integrated model does not resolve these moral questions directly, it has prescriptive implications. Minimally, I argue that it fares better than the standard three approaches.

Harm done to a patient within the psychiatric community is nothing new. The neglect, abuse and violence of many people with disabilities in medical communities are widespread problems that have been well documented (WHO, 2011; Mont, 2007). In 2015, Disability Rights International documented cases of neglect and abuse in over 25 countries, which included children with disabilities having been tied to beds in mental institutions. Moreover, the gendered nature of disability itself causes women and girls with disabilities to be more vulnerable. Mathews, Rosenthal, Ahern, and Kurylo (2015), documented the differential medical treatment of girls and women within orphanages and institutions with Ukraine (pp. 22-23). In orphanages in the Kharkiv region, girls are often taken to medical centers to begin treatment to limit their sexual development. For women, Ukrainian law allows for the sterilization of people with “psycho-social disorders” or “intellectual disabilities,” and as a result many women with these conditions have been sterilized without consent after being given an abortion. In the 2016 statement by the United Nations Special Rapporteur for People

with Disabilities, Ms. Devandas Aguilar argued that the situation of women and girls with disabilities is particularly precarious because many women and girls with disabilities do not have safe places to take part in open consultations with healthcare practitioners.

Yet violence, abuse and neglect are not the only ways a patient can be harmed in the medical community. Because the relationship between the mental health practitioner and the patient is a fragile relationship, a practitioner must be careful not to *silence* the patient's lived perspective. Miranda Fricker (2007), a philosopher, argues that silencing is a type of epistemic injustice when the individual, who is in the role of listener, does not accord the speaker the standard authority to have one's assertions taken as truth-claims without cause. Silencing, particularly, addresses the prejudice against speakers from historically oppressed social groups. By extension, mental health practitioners may be morally guilty of silencing their patients when they dismiss or ignore the perspective and lived stories of their patients in mental distress. An integrated approach would "give voice" to the patient in this fragile relationship and promote listening, rather than prescribing, in the therapeutic relationship.

The three models discussed earlier promote acts of silencing either directly or indirectly. The "Western" Model in particular promotes silencing patients in two ways. First, the "Western" model generally ignores the cultural framework animating a patient's life. This very framework may be pointing to differences in the cultural expression of the pathology. To illustrate this neglect of cultural framework consider a case of anorexia in Hong Kong. Dr. Sing Lee, a psychiatrist and researcher at the Chinese University of Hong Kong documented a rare and culturally specific form of anorexia nervosa in the 1980s and early 1990s. Unlike "American" anorexics, most of his patients did not intentionally diet nor did they express a fear of becoming fat. Rather, they complained of having bloated stomachs. As he was in the midst of publishing his finding that food refusal had a particular expression and meaning in Hong Kong, the public's understanding of anorexia suddenly shifted. On Nov. 24, 1994, a teenage anorexic girl named Charlene Hsu Chi-Yang

collapsed and died on a busy downtown street in Hong Kong. The death caught the attention of the media and was featured prominently in local papers such as “Anorexia made her all skin and bones: schoolgirl falls on ground dead.” In trying to explain what happened to Charlene, local reporters often simply copied out of American diagnostic manuals. The mental-health experts quoted in the Hong Kong papers and magazines confidently reported that anorexia in Hong Kong was the same disorder that appeared in the United States and Europe (Watters, 2010, chapter 1). The journalists in this case, then, silenced the cultural framework animating the lives of the young women Dr. Lee had observed. Rather than take into account the difference of the cultural expression of their pathology, the journalists assumed the “Western” condition of anorexia was identical across cultures.

A second way the “Western” Model silences patients is when there is no accurate translation of the cultural expression of the pathology into a “Western” framework. Silencing can occur in these cases as well because culture presents an “untranslatable barrier” for practitioners. “Zar” illustrates the difficulty of translating across cultural barriers. Diriye Abdullahi, a native of Somalia, describes zar as a dance of spirits, or a religious dance (Watters, 2010b). The zar is a spirit dance inspired from old African deities, a form of what we describe in the “West” as “voodoo.” Etymologically, the word “zar” is from the word for “visitation,” referring to being “visited” by a possessing spirit or demon. Many “Western” anthropologists have a tendency to look at possession through a “Western” lens and invariably attribute this strange phenomena to sociological or psychological reasons that lie within their own paradigms. Silencing occurs at this level when this cultural difference is lost because anthropologists assign a “Western” meaning to the practice.

The cultural competency model silences differences in cultural expressions of mental health as well. Unlike the “Western” model, the cultural competency model silences patients by making two assumptions: (1) it appropriates cultural stereotypes and bias about individuals and (2) assumes that one’s “culture” is

homogeneous or static. Kleinman and Benson (2006), in their article “Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It” present the following case study to highlight these two problems with this model. A widowed Mexican man, who is HIV positive, lives in California with his four-year-old son, who is also HIV positive. But the man has not been bringing the child in regularly for care. Using the cultural competency model, clinicians assumed that since the man is from Mexico, he has a different cultural understanding about HIV. An anthropologist was brought in and spoke with the man. The anthropologist discovered that the man was a very-low-paid bus driver, often works night shifts, and cannot take his son for treatments. The reason the man had missed appointments had not been because of a different cultural understanding of HIV as the clinicians had assumed. The clinicians had used a static understanding of culture to silence their patient rather than recognize his local, lived world. It is in this sense that the cultural competency model assumes a static understanding of “culture” rather than a “local” understanding. Anthropologists have cautioned against using this notion of “culture” in practices, because the idea of one’s culture cannot be found in large data sets. To the contrary, culture can only be understood in the particular (Watters, 2010, p. 139). Because of this, the cultural competency model appears to be detrimental to a patient’s health.

Finally, the holistic model is guilty of silencing the patient by forcing the adoption of a new “worldview” that is not shared by the patient. This shift in a worldview can be painful and difficult for the patient, and inadvertently cause more harm than good. In 2006, Lazarus conducted interviews with 25 individuals who were defined as either (a) people working in health and education contexts who were connected to Native American healing systems and practices or (b) individuals who had particular expertise working within Native American communities in health or education settings (p. 525). In this study, individuals often reported the need for the recognition of local differences to challenge dominant worldviews. The holistic view, like the “Western” Model, replaces one dominant view with another, and as a result cannot accommodate a diversity

of local worldviews. Thus, the holistic model silences the patient by forcing a shift away from the local to the general or holistic perspective for health.

In sum, the “Western” model, the cultural competency model and the holistic model provide a mental framework that can promote silencing of the patient’s lived local world. In mental healthcare, this silencing may contribute to relapse and social isolation in practice. From the perspective of moral philosophy, silencing constitutes an injustice, and so is not acceptable. Since these three options are flawed, we are left with the fourth option: the integrated alternative. This option, however, may only be morally permissible rather than morally obligatory. Stated differently, if the claim that we have a strong moral obligation to adopt the integrated alternative cannot be defended, then we should conclude that a model which integrates local cultural differences with biomedical benefits can only be suggestive rather than prescriptive. Whether this strong obligation can be defended is what I will now address.

Are we morally obligated to adopt the Integrated Model?

In this section, my aim is to provide arguments for two moral obligations to adopt the Integrated Model. I begin by presenting the “positive” obligation to promote good health to provide reasons to adopt the integrated model of mental health. Next, I turn to the stronger, “negative” obligation facing all mental health practitioners: the harm principle. Both the positive and negative obligations, then, will provide the requisite moral reasons for mental health practitioners to consider adopting the integrated alternative in practice.

Promoting Good Health

The most familiar ground for claiming that we have an obligation to promote good health for the public is *beneficence* (Powers & Faden, 2006; Institute of Medicine (USA), 2003; Thomas, Sage, Dillenberg & Guillory 2002; Nuffield Council on Bioethics, 2007; Kass, 2001; Venkatapuram, 2011; Gostin, 2012). If the Integrated Model can

demonstrate that it provides a more beneficent way to alleviate a patient's distressing symptoms, then morally we ought to promote this alternative. This seems reasonable when those in need may "live in two worlds" due to the legacy of colonial aggression. Their need to have treatment that resonates with both lived worlds calls for our adoption of a more promising kind of treatment, and the integrated model does just this. It does this first, because it adapts medical diagnosis and practice to local understandings with recognized existential meaning, and second, because it incorporates those local understandings into therapeutic practice.

The promotion of good health need not be limited solely to the individual. Communities, like individuals, are also vulnerable to forms of social, historical, political and economic colonizing frameworks. Various social and political institutions may only allow one dominant worldview to the detriment of the community members. At the national level, nations may only tolerate rather than promote practices that provide active social roles for those facing mental health issues. Only when they change their policies and institutions to promote group cohesion rather than social isolation, do their communities benefit. Thus, beneficence for the whole community provides secondary reasons to consider the integrated model of mental healthcare.

A case which illustrates the positive obligation to promote good health for the community is the decriminalization of drug use in Portugal. In 2001, Portugal decriminalized "the acquisition, possession, and personal use of small quantities of all psychoactive drugs, including heroin and cocaine" (Laqueur, 2014, p. 1). This shift in strategic practice from a penal approach to a therapeutic approach to drug abuse devoted "additional resources for the prevention, treatment, harm reduction and the social reintegration of drug users" within society (Ibid, p. 5). The "National Strategy" appropriated a humanistic and health-oriented approach that recognized the "addict" as an individual who was a "sick person" rather than as a "criminal" (Ibid). This removal of criminal penalties de-stigmatized the users and encouraged treatment. As a result of

this beneficent political change for their country, Portugal witnessed the number of individuals receiving treatment increase (Ibid, p. 23).

These points provide support for our positive obligation to promote the health and well-being of individuals within our shared community. The integrated model, understood as a blending of our contemporary understanding of brain biochemistry with the practices and traditions of a region that help make up a local worldview – whether that worldview includes the belief in zar by a Somalian or the belief in demons by an evangelical Christian living in Mississippi – should be adopted if the treatment outcomes for the patient are more likely to be beneficial. Thus, if the integrated alternative can provide better care for patients, then we should make use of the integrated model as an option for mental health treatment. The argument for the obligation to adopt the integrated alternative, however, need not stop here. These points express our positive obligation toward others, and pave the way for a more powerful argument recognized in medicine from the beginning of its history – the argument not to harm.

First, do no Harm

The Latin phrase, *primum non nocere* (first, do no harm), articulates the ground for the moral claim of *non-malificence* for medical practitioners for over the last 500 years (Miles 2004; Hulkower, 2010, p. 41). This part of the “Oath,” which is commonly referred to as the Hippocratic Oath, has been attributed in folk history to the Greek medical doctor Hippocrates, who charged health practitioners to “abstain from doing harm.”² Hippocrates, who according to legend could trace his ancestry back to Asclepius, the god of medicine and healing, emphasized in his writings that physicians should take the least damaging approach to treatment (Hulkower, 2010, p. 43). His writings are known for his emphasis on not only the need for empirical scientific investigation, but also the need for the

² According to Orr et al. (1997) it was Ludwig Edelstein (1902-1965) who provided evidence that the Hippocratic Oath may actually be the work of the followers of Pythagoras of Samos. In common folk history, however, the Oath is still attributed to Hippocrates.

importance of providing patient-centered medical care. Thus, to base one's notion of treatment only on scientific investigation is to neglect the second aspect of Hippocrates' charge to care for the patient: "I will do no harm or injustice to them" (Ibid).

Most moral theories prescribe strong "negative" duties or obligations not to harm others. If we do harm someone, then we must make amends for our actions. Furthermore, if we have evidence that a certain practice or treatment causes more physical harm or psychological distress, then we are obligated to cease that practice or treatment. Ignorance is not a defense. If we are not aware that we are causing or have caused harm, then, once we become aware, we must stop causing the harm and make up for the wrong action committed. If any of these reasons are morally right, then we have a negative duty to change our course of action. If all of these reasons are right, then our moral obligation to consider alternative models of mental health treatment is very strong.

Some might argue that there is no evidence of the psychological harm that they cause, and thus, their ignorance frees them of any moral obligation to consider alternative treatments. In this case our culpability in a patient's psychic harm is diminished because we were ignorant of the harm we were causing. I think the following analogous case study prompts serious reconsideration of a defense of harm caused by ignorance. In 2011, Köhler and researchers provided evidence of the harm in genital surgery performed on members of the intersex community with "XY disorders of sex development (DSD)" at birth to the medical community. While reports of harm have been well known for years by advocates, this "official study" provided strong evidence that genital surgery at birth should stop being practiced. Researchers found in their study, for example, that seventy percent of "XY DSD females" had problems with sexual desire and forty-seven percent of this same group experienced dissatisfaction with clitoral arousal. Moreover, seventy percent of individuals with androgen insensitivity syndrome (AIS) experienced dyspareunia. Researchers concluded that not only should care be included for these patients, but also that "constructive genital surgery should be minimized and

performed mainly in adolescence or adulthood with the patients' consent" (Köhler et al., 2011). Additionally, researchers recognized the need for a shift in psychological treatment and argued that "multi-disciplinary care with psychological and nonprofessional support (parents, peers, and support groups) should be mandatory from child to adulthood" (Ibid). While medical practitioners had assumed that the birth surgeries they were performing were beneficial to their intersex patients, they had been acting in ignorance of the harm they were causing. This official report has made that harm transparent. Similarly, as discussed in the introduction of this paper, the World Health Organization has found that those countries with the most resources devoted to mental healthcare (such as the United States and those in Europe) have the most troubled and socially marginalized patients. Are we not then obligated at least to consider alternative options if we already know that what we are doing is not working?

Others might argue that the harm of neglecting to use an integrated approach may be an unintended consequence rather than a form of maleficence. The argument might go as follows: since the mental health practitioners are only trained in providing pharmacological drugs and "Western" treatments, they are not culpable of any psychological distress or trauma that may occur as a result of treatment. While this argument is familiar, its weakness becomes obvious when we consider the following analogy. For instance, if I am a public high school biology teacher living in Oklahoma, and I also happen to have been taught and believe in Creationism, and choose only to teach what I have been taught, know and believe, then my actions have the unintended consequence of promoting ignorance in my students. I am at least partly responsible for presenting biased information to my students, even if my schoolboard policy allows that I teach this way in my classroom. In a similar vein, we would argue that just because one has not been trained in alternative therapies, and so chooses not to provide alternative options for one's patient, then this lack of malicious intention does not exculpate the practitioner from the unintended negative consequences for the patient's mental health.

Finally, one might consider a different kind of psychological harm that can occur in mental healthcare: the interpersonal harm that can be caused by silencing or by paternalistic practices. When a practitioner silences her patient by not listening to the patient's perspective, or is guilty of paternalistic behavior by assuming she knows what is best for her patient, even though her patient disagrees, this practitioner is committing acts of interpersonal harm. The negative obligation not to commit interpersonal harm may be considered a weaker claim in this overall series of arguments, but it should not be considered a lesser claim. An integrated approach provides a buffer against acts of interpersonal harm by its very model: the safe space for the patient's voice and perspective is integrated into the very framework.

Responsibility in Mental Health

Beneficence and the harm principle give us grounds to think that we have obligations to be responsible in mental healthcare practice. Further, they provide reasons for us to consider adopting possible alternative models of mental health such as the integrated model of care. There might, however, be one final hold-out objection. It could be argued that we still do not have enough evidence to adopt a change in our system. In response, I wonder whether this rebuttal gives us a reason not to consider the local lived world of the patient. I would think that it does not for the following reason: the questionable degree of epistemological uncertainty does not excuse inaction. Given the drawbacks of the alternatives, and the promise of the integrated model, the epistemic uncertainty in question is too insignificant to prevent action. The next steps for action would depend upon the relative psychological, physical and economical costs of adopting an integrated model versus those same costs of continuing the established biomedical narrative already in place.

Conclusion

The World Health Organization study points to the limits of "modern Western medicine" for care of the self. We must remember

that psychiatry cannot be equated with neurobiology (Rutten et al., 2013). McGruder's results of her Zanzibar study provide an answer to the tension that has perplexed so many practicing in global mental healthcare. Her research specifically demonstrates the need and the urgency to question the sole authority of the biomedical narrative.

The biomedical narrative of global mental health care has incorporated the colonizing power of theoretical frameworks in therapeutic practice. These models – the “Western,” the Cultural Competency, and the Holistic – have a tendency to dominate and silence the local, lived world of the patient. The integrated model of mental health, by contrast, offers a de-colonizing model that creates a space for the patient's voice to be heard and designates an active ongoing role within the patient's social group. My hope in this paper has been to provide a multi-layered argument for why we have strong obligations to implement the integrated model as a viable alternative for our current practices. These obligations have been both positive – the need to promote health and well-being – and negative – the need not to do more harm than good. Both of these obligations grant the moral foundation for our choices from here. Choosing not to silence, but to listen, really listen, is the first step in moral change.

Finally, by adopting an integrated model of mental health, we must be careful not to colonize the local views of the one in need for care due to a destructive power relation between the practitioner and the patient. “Speaking-for” their views, rather than “speaking-with” would also be an act of silencing. We must remember that people sometimes “choose” to be silent in order to protect indigenous knowledge from further colonization (Lazarus, 2006, p. 527). Listening can be accomplished by maintaining a self-reflective approach that challenges our own practices and reveals our own colonizing tendencies (Ibid, p. 540). Only then, can the relation between practitioner and patient begin to be one of healing. Healing one's suffering, one's trauma, and one's relation to one's community.

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