Empowering Medical Pluralism in Mental Healthcare: Critical Narrative Review with Case Illustration

Dr. Sameer Shaker[1], Abdullah Alahmari[2], Waleed Alsolami[2], Mohammed alsulami[2], Emtinan Feleimban[3], Mohammed Alshumrani[4], Dr. Nouf Alsayed[5], Nourah Alfaqeeh[6], Maha Alfaqeeh[6]

[1]*Bab Al Majidi Primary Healthcare Center, Ministry of Health, Saudi Arabia.*
[2]*Althager General Hospital, Ministry of Health, Saudi Arabia.*
[3]*Airport Polyclinic Center, Ministry of Health, Saudi Arabia.*
[4]*Prince Abdullmajeed Healthcare Center, Ministry of Health, Saudi Arabia.*
[5]*Jeddah First Health Cluster, Qowiza Healthcare Center, Ministry of Health, Saudi Arabia.*
[6]*Jeddah Second Health Cluster, Ministry of Health, Saudi Arabia.*

Abstract

Mental health conditions affect more than 900 million individuals across the globe. Unfortunately, the developing countries bear disproportionally higher percentages, which point towards a gap in the treatment programs or other external players. This review draws on a case study that identifies socioeconomic and cultural factors as the leading barriers of accessing mental healthcare services in the developing countries. Accordingly, we have proposed a philosophically driven farmwork that advocates for medical pluralism to address these obstacles. Nevertheless, it must be noted that more research is needed to validate this framework.

Keywords: mental health; developing countries; stigma; contemporary medicine; cultural competency.

Introduction

Mental health conditions are diverse and spread across the globe, cutting across the low- and high-income economies (Patel et al., 2018). The World Health Organization (2022) indicates that one in every eight individuals (more than 900 million) across the globe suffer from some form of mental illness; taking into consideration that some cases are undiagnosed. However, literature evidence indicates that despite the majority of the individuals residing in the low-income countries, these countries are critically disadvantaged regarding the identification, treatment and care for people with mental illness (Fernandez, 2022; Khalid et al., 2019; Rathod et al., 2017).

The current healthcare infrastructure in developing countries is burdened by socioeconomic and cultural factors that seems to be elusive to their healthcare systems' management (Adewale et al., 2016; Hays & Costello, 2022; Kpanake, 2018; Kopinak, 2015). This narrative review draws on a typical case study of a mental health patient to illustrate to the crucial negative with created by sociocultural phenomenon against achieving effective mental care. The review further culminates in the recommendation of medical pluralism within the Daoist philosophy of harmony and balance, to integrate traditional and complementary medicine with the conventional medical care to deliver culturally competent and comprehensive mental healthcare in these settings.

The case scenario

A few years ago, my attention was caught by a forlorn whimper of a child in a weathered hut sitting by the edge of the village footpath. It was a 9-year-old girl, looking dispirited in dry skin marked with abrasions, apparently pawed by life's troubles. This girl appeared metaphorically bound within the discomfort of sore eyes, dry lips and a myriad of other invisible challenges strolling the realm of her survival. Despite her mental illness, she greeted me with a broad smile, the genuine innocence of a child who justly deserves a complete care. Her mother had gone looking for water distant away. Unfortunately, the girl's mother, being a staunch believer and a devotee of traditional medicine, never registered this girl for any conventional medical care. Her first attempt to present the daughter to the nearby hospital for a checkup and treatment only met an unforgettable dejection after a nurse sent her back to bathe the sickling daughter. This was against the instructions given by her traditional healer. She became traumatized, stigmatized and resentful of the hospital services. She often cited examples of many mental illness cases that never improved after hospital intervention, which confided her stern stance against Western medicine.

The problem of mental healthcare in low developing countries

This case of the girl presented above is a typical scenario of how stigma, devaluation-discrimination, culture, poverty, and contempt impede health-seeking behaviors among people with mental illnesses. Indeed, there is an abundance of literature that cites the impeding effects of stigma and devaluation-discrimination, culture and even low income as the core socioeconomic factor jeopardizing mental healthcare in the developing countries (Henderson et al., 2014; Javed et al., 2021; Jani et al., 2021; Mascayano et al., 2016; Semrau et al., 2015). In fact, stigma is considered so mighty that it can defiantly affect even the mental care service and help-seeking behaviors in the developed countries (Clement et al., 2015; Jones et al., 2018).

These socioeconomic factors performantly stand out as the Achilles' heel in mental healthcare. Unfortunately, Nyblade et al. (2019) indicate that almost every part of the world has a population critically torn by stigma and controversies over mental healthcare. Moreover, the recent empirical evidence presented by Evans et al. (2023) expresses that "…personal stigma significantly predicted attitudes towards help-seeking" (p. 1). In another example, Birkie and Anbesaw (2021) also found that knowledge deficiency and negative attitudes critically affect health-seeking practices among people with mental illnesses. The quantity and quality of evidence supporting the negative impacts of stigma and other social factors in mental health help-seeking practices is unequivocally enormous.

Whereas there are no conclusive research reports about the superiority of any intervention in treating mental health problems, it is mostly acceptable that stigma and devaluation-discrimination, in their full capacity, can critically hamper delivery of any care services, conventional and non-conventional alike (Clement et al., 2015). Hence, a question stands out on what then should be done to address the elephant in the house. However, before that, it is paramount to acknowledge the pieces of evidence that are already established about the intervention approaches in place. To this regard, many interventions have been rolled out, including health workers' training, awareness campaigns, multilingual health communication, peer support networks, telehealth services, etc., (Koly et al., 2021; Mollah et al., 2018; Rice & Harris, 2021). All these have been ascertained through conventional research processes as reliable means of addressing the problem at hand. Yet, the problem still lingers in the developing countries.

A framework to support medical pluralism

To some extent, Austin (2022) indicates that a blame could be put on translational research for the gaps in practice amidst the abundance of evidence about mental healthcare service-seeking. Still, there still seems to be an elusive tail of the problem wagging loose in the low-

income countries. Therefore, a promising solution would to fully empower medical pluralism – integrating non-conventional, alternative and complementary medicine within the standard/conventional care (Bahceci et al., 2013; Seet et al., 2020; Thirthalli et al., 2016). However, this is a complex and delicate process that needs coordination among the international, national and local leadership, guided by a feasible framework.

Since there is a need to keep every practice towards addressing the poor status of mental health help-seeking behaviors under check, a framework is recommended. The most adaptable and relevant farmwork to penetrate and address the socioeconomic and cultural barriers is one that inculcates and harmoniously integrate a philosophical and religious stance, tradition, and modern medicine to penetrate barriers in mental healthcare as recommended by Fox et al. (2018). However, the model should be personalized to every patient scenario due to the diversity in peoples' backgrounds and beliefs (Casados, 2017).

The proposed model would lean on the Chinese philosophy of Daoism and its affiliate schools of thought that advocate for harmonious living with the natural way of the universe (Şenel, 2022). Interestingly, this philosophy has been applied in some healthcare cases (Chung & Fitzsimons, 2015; Ming, 2018). Daoism is primed on balancing the 'Yin and Yang' – in this case, establishing an equilibrium between traditional and contemporary medicine and the beliefs surrounding them (Stanley-Baker, 2022). Consider the example of the girl's mother, whose hopes were shattered upon meeting a health worker incognizant of alternative medicine. Her case would be best solved by a smooth transition from traditional to contemporary medicine; in fact, some scholars champion such smoothness (Betancourt et al., 2016).

Using the same model, international healthcare organizations, such as the World Health Organization, would advocate for harmonious care that inculcates different approaches. In the process, religious and cultural beliefs would cling to space and earn respect in the social and medical arena. The significance of religion and spirituality in holistic care is apparent in empirical evidence (Garssen et al., 2021; Vitorino et al., 2018). The approach would tackle the problem from its roots since stigma originates at home when the community negatively perceives mentally ill individuals. Therefore, international organizations need to communicate with the local leadership structures to discourage discrimination that would hinder their efforts to seek help. For example, the religious leadership should develop viable programs to encourage positive living among mentally ill individuals and encourage them to seek relevant help. The locals should also be urged to support such individuals emotionally, spiritually and even financially.

After establishing a landing point in society, healthcare management in every region needs to build a welcoming state in every institution to offer culturally competent care. In this way, we would establish an equilibrium stance that empowers patients to practice cultural and/or religious practices that they believe would enhance their recovery. Still, the local leadership of health institutions must also embrace a culture of living harmoniously with diverse patients' beliefs since diseases, just like cultural beliefs, are natural aspects of our universe.

Conclusion

The barriers against mental healthcare in the developing countries are deeply rooted that not a single healthcare intervention may help to address them. Therefore, drawing on a comprehensive working framework might help address the predicament. According to the Daoist philosophy, the societal success thrives in harmony, and so should be the pillar of medical pluralism. On the other hand, stigma flourishes in dissonance, where knowledge and belief differ. Hence, one of the most promising and most appropriate approach to address mental health problems is to embrace a harmonious model that creates space for

alternative medicine within mainstream modern medicine and in the context of Daoism.

Recommendations

This narrative review has only outlaid the foundation of the potentiality of applying a philosophically driven framework in addressing mental healthcare challenges in the developing countries. Nevertheless, current empirical evidence should be sought to establish the validity of these proposed ideas before applying on the actual healthcare settings.

Conflict of interest

The authors of this study hold no conflict of interest as far as this research article is concerned.

Reference

[1] Adewale, V., Ritchie, D., & Skeels, S. E. (2016). African-American and African perspectives on mental health: A pilot study of the pre and post colonial and slavery influences and their implications on mental health. Journal of Communication in Healthcare, 9(2), 78-89. https://doi.org/10.1080/17538068.2016.11 70316

[2] Austin C. P. (2021). Opportunities and challenges in translational science. Clinical and translational science, 14(5), 1629–1647. https://doi.org/10.1111/cts.13055

[3] Bahceci, B., Bagcioglu, E., Ozturk, A., Bulbul, F., Sahiner, I. V., Tuncer, B. E., Guzel, H. İ., & Hocaoglu, C. (2013). Complementary and alternative medicine use in patients with mental disorders in Turkey. Complementary therapies in clinical practice, 19(4), 221–226. https://doi.org/10.1016/j.ctcp.2013.06.005

[4] Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

[5] Birkie, M., & Anbesaw, T. (2021). Knowledge, attitude, and associated factors towards mental illness among residents of Dessie town, northeast, Ethiopia, a cross-sectional study. BMC psychiatry, 21(1), 614. https://doi.org/10.1186/s12888-021-03609-0

[6] Casados, A. T. (2017). Reducing the stigma of mental illness: Current approaches and future directions. Clinical Psychology: Science and Practice, 24(3), 306. https://psycnet.apa.org/doi/10.1111/cpsp.1 2206

[7] Chung, S., & Fitzsimons, V. (2015). Nursing and Daoism: Wading in the River of Practice. Creative nursing, 21(4), 245–249. https://doi.org/10.1891/1078-4535.21.4.245

[8] Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. Psychological medicine, 45(1), 11–27. https://doi.org/10.1017/S00332917140001 29

[9] Evans, L., Chang, A., Dehon, J., Streb, M., Bruce, M., Clark, E., & Handal, P. (2023). The relationships between perceived mental illness prevalence, mental illness stigma, and attitudes toward help-seeking. Current psychology (New Brunswick, N.J.), 1–10. Advance online publication. https://doi.org/10.1007/s12144-023-04329-2

[10] Fernandez A. (2022). Mental health gaps characteristics in the management of schizophrenia in a developing upper middle-income South-East Asian country. Asian journal of psychiatry, 74, 103170. https://doi.org/10.1016/j.ajp.2022.103170

[11] Fox, A. B., Earnshaw, V. A., Taverna, E. C., & Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The

mental illness stigma framework and critical review of measures. Stigma and health, 3(4), 348. https://doi.org/10.1186/s12889-022-13775-9

[12] Garssen, B., Visser, A., & Pool, G. (2021). Does spirituality or religion positively affect mental health? Meta-analysis of longitudinal studies. The International Journal for the Psychology of Religion, 31(1), 4-20. https://doi.org/10.1080/10508619.2020.1729570

[13] Hays, K., & Costello, J. (2022). Reflections on the cultural adaptations and implementation challenges of mental health first aid in Uganda: A case study. Psychological services, 19(Suppl 2), 95–101. https://doi.org/10.1037/ser0000549

[14] Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., Schulze, B., Druss, B., & Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. The lancet. Psychiatry, 1(6), 467–482. https://doi.org/10.1016/S2215-0366(14)00023-6

[15] Jani, A., Ravishankar, S., Kumar, N., Vimitha, J., Shah, S., Pari, A., & Ramasubramaniam, C. (2021). Factors influencing care-seeking behaviour for mental illness in India: a situational analysis in Tamil Nadu. Journal of public health (Oxford, England), 43(Suppl 2), ii10–ii16. https://doi.org/10.1093/pubmed/fdab131

[16] Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., Ng, B., Ramy, H., Saha, G., Arifeen, S., Elorza, P. M., Ratnasingham, P., & Azeem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low- and middle-income countries. Asian journal of psychiatry, 58, 102601. https://doi.org/10.1016/j.ajp.2021.102601

[17] Jones, N., Whybrow, D., & Coetzee, R. (2018). UK military doctors; stigma, mental health and help-seeking: a comparative cohort study. Journal of the Royal Army Medical Corps, 164(4), 259–266. https://doi.org/10.1136/jramc-2018-000928

[18] Khalid, A., Qadir, F., Chan, S. W. Y., & Schwannauer, M. (2019). Adolescents' mental health and well-being in developing countries: a cross-sectional survey from Pakistan. Journal of mental health (Abingdon, England), 28(4), 389–396. https://doi.org/10.1080/09638237.2018.1521919

[19] Koly, K. N., Baskin, C., Khanam, I., Rao, M., Rasheed, S., Law, G. R., Sarker, F., & Gnani, S. (2021). Educational and Training Interventions Aimed at Healthcare Workers in the Detection and Management of People With Mental Health Conditions in South and South-East Asia: A Systematic Review. Frontiers in psychiatry, 12, 741328. https://doi.org/10.3389/fpsyt.2021.741328

[20] Kopinak J. K. (2015). Mental Health in Developing Countries: Challenges and Opportunities in Introducing Western Mental Health System in Uganda. International journal of MCH and AIDS, 3(1), 22–30. https://pubmed.ncbi.nlm.nih.gov/27621983

[21] Kpanake, L. (2018). Cultural concepts of the person and mental health in Africa. Transcultural psychiatry, 55(2), 198-218. https://doi.org/10.1177/1363461517749435

[22] Mascayano, F., Tapia, T., Schilling, S., Alvarado, R., Tapia, E., Lips, W., & Yang, L. H. (2016). Stigma toward mental illness in Latin America and the Caribbean: a systematic review. Revista brasileira de psiquiatria (Sao Paulo, Brazil : 1999), 38(1), 73–85. https://doi.org/10.1590/1516-4446-2015-1652

[23] Mental Health Management Group (2023). Mental Health Management Group. 2023. The Role of Cultural Competence in Mental Health.

[24] Ming, L. (2018). Yin yang philosophy and Chinese mental health. In Psychoanalysis in China (pp. 62-72). Routledge.

[25] Mollah, T. N., Antoniades, J., Lafeer, F. I., & Brijnath, B. (2018). How do mental health practitioners operationalise cultural competency in everyday practice? A qualitative analysis. BMC health services research, 18(1), 480. https://doi.org/10.1186/s12913-018-3296-2

[26] Nyblade, L., Stockton, M. A., Giger, K., Bond, V., Ekstrand, M. L., Lean, R. M., Mitchell, E. M. H., Nelson, R. E., Sapag, J. C., Siraprapasiri, T., Turan, J., & Wouters, E. (2019). Stigma in health facilities: why it matters and how we can change it. BMC medicine, 17(1), 25. https://doi.org/10.1186/s12916-019-1256-2

[27] Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., Prince, M., … UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. Lancet (London, England), 392(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

[28] Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental Health Service Provision in Low- and Middle-Income Countries. Health services insights, 10, 1178632917694350. https://doi.org/10.1177/1178632917694350

[29] Rice, A. N., & Harris, S. C. (2021). Issues of cultural competence in mental health care. Journal of the American Pharmacists Association : JAPhA, 61(1), e65–e68. https://doi.org/10.1016/j.japh.2020.10.015

[30] Seet, V., Abdin, E., Vaingankar, J. A., Shahwan, S., Chang, S., Lee, B., Chong, S. A., & Subramaniam, M. (2020). The use of complementary and alternative medicine in a multi-ethnic Asian population: results from the 2016 Singapore Mental Health Study. BMC complementary medicine and therapies, 20(1), 52. https://doi.org/10.1186/s12906-020-2843-7

[31] Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L., & Thornicroft, G. (2015). Stigma and discrimination related to mental illness in low- and middle-income countries. Epidemiology and psychiatric sciences, 24(5), 382–394. https://doi.org/10.1017/S2045796015000359

[32] Şenel, E. (2022). Health and Chinese beliefs: A scientometric analysis of health literature related to Taoism and Confucianism. Journal of religion and health, 61(4), 2663-2678. https://doi.org/10.1007/s10943-020-01043-2

[33] Stanley-Baker, M. (2022). Daoism and Medicine. In Routledge Handbook of Chinese Medicine (pp. 401-416). Routledge.

[34] Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., Hankey, A., Wang, G., Gangadhar, B. N., Nie, J. B., & Nichter, M. (2016). Traditional, complementary, and alternative medicine approaches to mental health care and psychological wellbeing in India and China. The lancet. Psychiatry, 3(7), 660–672. https://doi.org/10.1016/S2215-0366(16)30025-6

[35] VanderWeele, T. J. (2017). Religion and health: A synthesis. Spirituality and religion within the culture of medicine: From evidence to practice, 419, 357-401.

[36] Vitorino, L. M., Lucchetti, G., Leão, F. C., Vallada, H., & Peres, M. F. P. (2018). The association between spirituality and religiousness and mental health. Scientific reports, 8(1), 17233. https://doi.org/10.1038/s41598-018-35380-w

[37] WHO (2022, June 8). Mental Health. https://www.who.int/news-room/fact-sheets/detail/mental-disorders