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Explanatory models of schizophrenia

Das *et al* (2006) assessed the efficacy of interventions to change explanatory models of schizophrenia among relatives of people with schizophrenia in India. They claim that their educational intervention presented the biomedical model without dismissing non-biomedical models and that indigenous beliefs were not challenged. Depending on the way in which the intervention was delivered, one can argue that presenting biomedical models is in itself directly challenging to indigenous beliefs. Although the authors found that their educational programme significantly reduced the number of non-biomedical beliefs, this does not say anything about the quality or depth of these beliefs. Moreover, the description of participants' beliefs as 'persistent' and 'resistant' suggests that the authors consider holding alternative explanatory beliefs to be problematic. They further justified their aim by suggesting that holding indigenous beliefs contributes to a poor outcome, which they defined as not recognising a biomedical explanation of schizophrenia and not adhering to medication. This is circular logic, using a very limited construction of outcome.

Despite citing a paper by Angermeyer's German research team, Das *et al* miss their important and consistent finding that biomedical causal beliefs are significantly related to negative attitudes (e.g. Angermeyer & Matschinger, 2003). Such negative consequences of holding biomedical causal beliefs have been found in numerous countries among the public, relatives and patients with severe mental illness (Read & Haslam, 2004; Read *et al*, 2006).

How does exporting the beliefs of Western experts to low- and middle-income countries fit with the consistent finding that these countries have much better outcomes for 'schizophrenia' than Western countries (Harrison *et al*, 2001)?

Finally, Das *et al* recommend that the advantages of medication should be discussed without dismissing or challenging indigenous explanatory models. We cannot assume that the challenge is not inherent in the underlying principles of the belief systems themselves. Investigating ways in which biomedical explanations can be discussed in conjunction with cultural beliefs is a constant challenge that will not be helped by reducing the prevalence of one set of beliefs.

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Read, J. & Haslam, N. (2004) Public opinion: bad things happen and can drive you crazy. In *Models of Madness* (eds J. Read, R. Bentall & L. Mosher), pp. 133–146. Hove: Routledge.

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doi: 10.1192/bjp.189.3.284

Authors' reply: We agree with Taitimu & Read that discussing biomedical beliefs in conjunction with indigenous beliefs in the clinical setting is challenging. However, patients, their relatives and the general public seem to simultaneously hold multiple and contradictory beliefs related to mental illness and its treatment (Joel *et al*, 2003). Biomedical explanations (e.g. disease, abnormality, infection, degeneration, etc.) often coexist with indigenous beliefs (e.g. supernatural causation, sin and punishment, karma, etc.) in many cultures (Saravanan *et al*, 2004). It is common for people in India to simultaneously seek help and treatment from practitioners of modern medicine and from traditional and faith healers (Jacob, 1999). This may not lead to conflict providing that each practitioner does not claim exclusivity. We have hypothesised that such multiple models may be advantageous, 'buffering' notions of loss and stigma and preventing social disintegration (Saravanan *et al*, 2004).

We agree that the acceptance of mental illness labels may increase perceived stigma. Nevertheless, holding alternative beliefs of causality also has costs. This is particularly true for people with chronic psychosis for whom antipsychotic medication has a powerful effect on outcome. Studies which have reported a better outcome for people with schizophrenia from low- and middle-income countries included many patients on psychotropic medication. The complete failure to subscribe to a disease model often results in a delay in seeking treatment and a poorer outcome.

The acknowledgement that individual health systems do not comprehensively address every issue for all mental disorders is useful in patient care (Jacob, 1999). It provides for alternatives in clinical situations, especially for psychiatrists practising in non-Western cultures, and allows the use of regional therapies, yoga and meditation, and respects folk beliefs and religions. Many experienced psychiatrists working in non-Western cultures employ cultural constructs and local treatments in their practice. Although psychological constructs are easily incorporated, traditional physical therapies are seldom used owing to the poor understanding of their active principles. Only a minority of mental health professionals in low- and middle-income countries rigidly function within Western frameworks. The majority acknowledge the ethnocentricity of psychiatry and its treatment techniques and the equally effective traditional alternatives. An eclectic approach and a liberal framework will enable psychiatrists to incorporate local cultural beliefs and traditional psychological treatments in therapy, thus increasing the therapeutic armamentarium.