



FEATURE ARTICLE

Talking science and wishing for miracles: Understanding cultures of mental health practice

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ABSTRACT: *Science can only offer a limited account of, and prescription for, mental health care. Yet the language of science and faith in the universal applicability of particular scientific methods to the craft of mental health care has come to permeate mental health practice communities. In this paper, the argument that many beliefs held by mental health professionals might be considered to be based on faith rather than science is presented, and the view that culture provides a useful lens for understanding mental health services and these paradoxes is proposed. Clearly there is a grand mental health narrative or colonizing influence of biological psychiatry that in various ways affects all mainstream mental health services. Local health services and professional communities might be considered subcultures. Understanding how mental health professions and practice are embedded in culture might be useful in considering how practice changes and why. Culture and caring practices are mutually embedded in localized subcultures. Therefore, a rich description of context and history is necessary in publication, presentation, or other communications to enable genuine understanding by a global audience. Viewing mental health practice in a cultural context highlights the importance of values and differences, and encourages humility in the face of ambiguity.*

KEY WORDS: *attitude, evidence-based practice, culture, discourse, mental health practice.*

INTRODUCTION

A cursory review of the scholarly literature in the fields of psychiatry/psychiatric nursing might lead one to conclude that mental health services have come of age, and we now enjoy a shared scientific understanding of the field and the best way to promote health and treat illness. Schizophrenia and bipolar have been declared 'brain disorders', although the World Health Organization now uses the term 'neuropsychiatric disorder' (World Health Organization 2011) to cover the burgeoning taxonomy of disease and illness presumed to have a

biogenetic basis. Prominent voices within the evidence-based practice (EBP) movement are beginning to deliver highly-prescriptive guidelines that 'define what high quality care should look like for a specific disease, condition or clinical area' (National Institute for Health & Clinical Excellence 2012). The argument that contentious questions about psychiatry are not in fact settled, and the idea that there are universal truths about mental health, illness, and mental health practice is illusory are presented in this paper.

The degree to which the mental health field is informed by science is first examined, and it is proposed that movements, such as 'evidence-based medicine' (EBM), have fostered a scientific worldview among many members of the mental health community; that is, a belief in the universal applicability of particular scientific methods and a belief that practice is actually founded on science. Science is clearly important, but the authority that is claimed from being 'scientific' is not in keeping

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with the actual advances in understanding that science has delivered. Second, the argument that in many respects the mental health field and orthodox beliefs are similar to religious or 'faith-based' beliefs is also presented. These propositions are not based on or argued from an exhaustive review of the literature. Indeed, such propositions, much like many in psychiatry, cannot be proved or falsified using such methods. Rather, these propositions are supported with logic and salient examples. Considering mental health fields as 'cultures of care' is proposed as a way to understand variations in practice, the ambiguity of conflicting beliefs, and to consider the processes that might be needed to advance understanding and improve the delivery of mental health services. A cultural approach foregrounds beliefs, traditions, history, and local context in understanding practice and practice change.

EBP AND THE CONSTRUCTION OF A SCIENTIFIC MENTAL HEALTH CULTURE

Most people would readily accept the need for 'evidence-based' psychiatric practice. The notion of EBP has become so embedded in the culture of mental health service that it might surprise many people that the very term 'EBM' was only coined in 1990 (Guyatt *et al.* 2008). The applicability of EBM to psychiatry has been challenged, especially in relation to the elevation of particular forms of research, and the promotion of standardized treatment packages for presumably standardized problems. For example, Gupta (2007) argues that EBM is problematic, because psychiatric illnesses do not reflect etiological or prognostically-homogenous groupings, and the quantification of psychiatric outcomes fail to capture the personal meaning of the illness or recovery experience. Williams and Garner (2002) assert that EBM is but one element in the complexity of clinical decision-making, and Mickenautsch (2010) states that controlled trials and meta-analyses can inform the analytic knowledge of practitioners, but cannot replace it.

Despite considerable criticisms of the limitations of EBM and the aforementioned caveats, it has powerfully affected how mental illness has come to be understood and treated. Gupta (2007) suggests that EBM promotes a view that mental illness can be understood in exactly the same way as any other kind of disease; that is, as fundamentally biological disorders, rather than psychological or experiential ones. EBM elevates pharmacological treatments and tightly-controlled or manualized interventions, because these can easily be subject to randomized, controlled trials (even if important assumptions about the

homogeneity of patient characteristics or diagnosis are violated). Thus, simple interventions can come to be seen as scientific or 'evidence based', and more complex interventions tailored to individuals (whether effective or not) are often considered less scientific. The tools utilized in, and often developed for, controlled trials, such as standardized tests and rating scales, have also been imported into routine practice, and lend an air of certainty to the otherwise messy craft of helping people (Lakeman 2004).

Psychiatry has long aspired to be a scientific discipline, but even a cursory glimpse at the history of psychiatry reveals this to be an aspiration many steps removed from reality. Klein (2010, p. 13) notes, in relation to his involvement in the development of the Diagnostic and Statistical Manual (DSM)-III (the prototype and template for subsequent revisions of the diagnostic formulary), that they are 'not driven by scientific advances nor the triumph of biologism, but rather a need to develop a common language'.

To this day, most, if not all, somatic psychiatric treatments have been discovered by accident. Klein (2010, p. 13) suggests that all current psychotropic agents are the 'offspring of serendipitous observations', and despite much research, no actually new psychotropic agents have been found. Typically, a chemical agent is noticed to have an effect on some aspect of cognition, mood, or behaviour, and based on an understanding of which neurotransmitter systems are affected by the drug, a theory regarding the pathogenesis or aetiology of the problem is borne. Thus, today lay and professional people alike have come to accept propositions, such as the notion that depression is caused by an 'imbalance' or deficiency of serotonin. This is based on the perceived efficacy of selective serotonin reuptake inhibitors (SSRI). Interestingly, a drug called tianeptine, which is a selective serotonin reuptake enhancer (with the opposite effect of SSRIs) appears at least as effective an antidepressant as other classes (Defrance *et al.* 1988), but such paradoxes and contradictions tend to be accommodated without great debate.

Dopamine dysregulation theories rapidly usurped psychodynamic theories of psychosis since the 1950s, despite no intrinsic dopamine deficit having been found (see Moncrieff 2009). As different classes of drugs are found to have similar effects, the theories of pathology are adapted and accepted endlessly. However, this defies logic. For example, one would not jump to the conclusion that pain is due to an opiate deficiency, or that a fever is due to an imbalance of antibiotics. The logic that biological treatment confirms a biological basis for disorder is a poor epistemological basis for any discipline.

Insel (2009) who is a vocal champion of what appears to be the emerging dominant orthodoxy of mental illness as distributed 'brain disorder' (problems of brain circuitry, rather than of focal lesions or simple chemical imbalances), suggests that focusing on how medications work might have been revealing if they were curative (which they are not), and thus, we know much about how drugs work, but little about the pathophysiology of psychosis and mood regulation. As Bell (2005) noted in a commentary on the exponential rise in the use of antidepressants in Australia, the history of medicine, but psychiatry in particular, is an unfolding story of orthodoxies that have been superseded.

Insel (2009) stated that much of what he had been taught as a resident in psychiatry 30 years ago 'has been proven utterly wrong' (p. 700). Despite, the apparently parlous state of psychiatric knowledge, there is a long history of presenting the current state of psychiatric knowledge as near irrefutable truth. Ellery (1941, p. 84), for example, when talking of 'insulin coma therapy', the now discredited, but only 'specific treatment' for schizophrenia from the late 1930s until the late 1950s, stated:

Men want miracles. And since Moses became outmoded, science has supplied the need. Time after time in the laboratory of the scientist the impossible has been made possible and the unbelievable come true. Medicine has worked miracles with a profligate hand – giving sight to the blind and new life to the dying. Insulin is one of these minor miracles.

The detailed descriptions of improvements in social functioning, fading psychotic symptoms, correction of homo or auto-erotic trends, and improved concentration attributed by Ellery (1941) to insulin coma therapy is indeed impressive, if not miraculous. Those who have received insulin coma therapy were estimated to receive between 50–100 times more face-to-face medical and nursing care than those not prescribed the treatment, by exceptionally enthusiastic and hopeful attendants who truly believed that this was an efficacious treatment (Jones 2000). Many inevitably did improve with such care. When insulin coma therapy was eventually disproven in a carefully-controlled trial (Ackner *et al.* 1957), psychiatry had largely moved on to its next miracle cure. Within 8 months of the drug chlorpromazine being introduced, approximately two million patients had received it with the promise that it was 70% effective in relieving symptoms of schizophrenia, but without inducing a coma (Rosenbloom 2002). Its effects were directly compared to (Winkelman 1954), and ultimately supplanted the other popular treatment of the time, 'lobotomy'.

There are many ways that one might view the history of psychiatry, including that new treatments have evolved, replacing more dangerous, less effective ones, and our understanding of psychopathology has also grown in parallel. It might be that mental health care is more enlightened today than it once was; however, it is also the case that speculations about the nature of mental health, illness, and treatment continue to be asserted as facts (Szasz 1987).

There is also little doubt that in most countries there has been a shift in espoused values towards mental health service users, and a greater acknowledgement of and concern for protecting people's human rights. For example, today the idea of lobotomizing someone, even without coercion, would be repugnant to most health professionals and lay people. However, some mental health service environments remain resistant to change (see Lakeman 2011). This all points to the business of mental health care (because it is unquestionably a business that provides a very good living for multitudes of people) being far from a science, and it would betray history to suggest that the authority of psychiatry (and associated professions) is founded on science. Some, such as Frith (2008), seek to reconstruct or rebrand psychiatry into 'neuropsychiatry'. However, this is an act of faith that such a movement will ultimately deliver better care. To date, and despite huge investment, this sociopolitical repositioning has delivered little tangible benefit to people who currently use mental health services.

QUASI-RELIGIOUS FLAVOUR OF THE MENTAL HEALTH INDUSTRY

Psychiatry has long been likened to a religion, although today perhaps we are less likely to talk about psychiatry as the worker of miracles, as Ellery (1941) did, and more likely to evoke wonder through the use of scientific language. Most schools of psychotherapy (which many health professionals align to) are associated with charismatic leaders revered by their followers, and it seems that medical spokespeople (much like bishops or Imams) can make pronouncements on any social matter on the basis of conferred authority over all things to do with well-being. Szasz (1973) is perhaps most famous for likening psychiatry to a secular religion, and he draws parallels between the modern methods of psychiatry and medieval methods of identifying and punishing witches, heretics, and Jews. The 'psychiatric bible' or DSM has been likened to the 'malleus maleficarum' (or witch-finders bible) by some. Countless others have pondered how a medical 'science' can vote in and out various disorders,

and who stands to gain and lose from such processes (Sorboro 2010). Whether one perceives the outcome of all this as being essentially good, natural, or malign, so much of what people take for granted in mental health is based on faith.

Although couched differently, we now appreciate that faith in a treatment (the placebo effect) and faith that a person will improve (essential components of a therapeutic alliance) are in most instances the most powerful predictors of improvement for those receiving psychotherapy or pharmacotherapy (Krupnick *et al.* 1996; MacNeil *et al.* 2009; Martin *et al.* 2000). Faith is central to the structure of authority in mental health systems, and enables mental health systems to work and for people to engage in otherwise unpalatable activities. For example, occupational groups, such as nurses, sometimes coercively administer treatments prescribed by others. They must maintain faith that the treatments do or will work, and arguably, they must have faith in the knowledge and virtue of the prescriber. Research suggests that nurses undertake such activities believing they are doing good (even in the absence of strong evidence to support this), and experience considerable dissonance and tension when they do not have faith in the efficacy of treatment (Olofsson *et al.* 1998; Vuckovich & Artinian 2005).

Faith is to a large extent justified and maintained by appealing to or through scientific discourse. Even if there is little scientific basis for much of what people actually do in practice, people often express great faith that neuroscience, genomics, or neuro-imaging will eventually explain and offer scientific validation for existing ideas and practice. For example, Insel (2009) proposes that science disproved much that was known as truth 30 years ago, but makes a faith-based assertion that mental illness has a physiological cause (albeit a complex one). Similarly, Frith (2008) suggests that current understandings of schizophrenia are simplistic, but asserts that 'it is' a brain disorder and cognitive neuropsychiatry will ultimately offer the best explanations. Science has a lot to prove, as despite such rhetoric, there is not one biological test ready for inclusion in the criteria sets for the DSM-V (Sorboro 2010), and we have not discovered the aetiology of a single diagnosis introduced in the DSM-IV (Sobo 2012).

The development of the DSM-III promised to provide some degree of certainty by offering a reliable way of categorizing human experience. In this, it was successful. Revisions of the diagnostic manuals have expanded the number of disorders and the reach of medicine and allied health professions into all manner of problems previously not considered within their purview.

The validity of these categories has been challenged by a great many from within the mental health professions (e.g. Patel 2001). Indeed, the editor of the DSM-IV, Allen Frances (2010, p. 6) recently stated that 'mental disorders don't really live "out there" waiting to be explained. They are constructs we have made up – and often not very compelling ones at that'. He goes on to acknowledge with regret that changing a word or two in the DSM has triggered an "epidemic" of false positives (as in Attention Deficit Disorder)' (p. 6). Regardless of such authoritative critique, the drive to expand categories and extend the use of such manuals has been relentless, as has the drive to standardize approaches to problems (made, of course, easier by the standardized nomenclature therein). It is a profound example of faith that psychiatric diagnosis are seen by many as representing diseases, and that psychiatric drugs 'treat' underlying disease processes (Moncrieff 2009).

Sorboro (2010) suggests that a problem with the DSM, being purely descriptive, atheoretical, and untied to any verifiable pathology is that it is 'not even wrong', that is it is based on assumptions that cannot possibly be falsified or used to predict anything. One can speculate about what might have caused someone to feel depressed, but one cannot prove that an entity is depression. Mental illness might be considered a fiction in the sense that Spinoza (1997) used the term, as an idea created out of other ideas. As such it cannot possibly be proved wrong. A catalogue of symptom lists cannot be proved wrong, although it is entirely possible to project all manner of wrong theories and interventions on people so categorized. Jureidini (2012) recently called psychiatric diagnosis 'unexplanations'; that is, they do not just fail to explain, but they stand in the way of authentic understanding. Mental illness, like many of the concepts employed through common language in mental health services, are like religious concepts, in that they are neither true nor false. They are conceptions based on experience, a way of structuring experience, and provide a means by which we might try and make sense of our lives.

CULTURES OF MENTAL HEALTH CARE

The fabric of mental health communities often appears to be held together by assumptions and beliefs more akin to religious convictions than the rational, impartial, sceptical, detached, and critical attitudes usually associated with science. Nevertheless, mental health practice is not a religion, and there appear to be numerous dissenters, if not heretics, that are accommodated within the mental health field. Fancher (1995) suggests that we ought to

view mental health services as 'cultures of care'. This makes intuitive sense if we think of the total institution that Goffman (1991) so famously described. The idea of the total institution will have resonance with most health professionals who have worked in large psychiatric hospitals, with their own norms, rituals, traditions, and so forth. Cultures are created to meet social needs and wishes, and what service improvement really means in many places is a shift in culture.

Fancher (1995, p. 11) acknowledges that:

Mental health care like most human endeavors is a field in which we do the best we can, by whatever activities seem to work, to solve what seem to us to be problems. Communities of like-minded people develop beliefs and practices, teach them to each other, reinforce them as the standard beliefs of the community, and lose sight of the fact that those beliefs and practices are their own make-do creations. Settled beliefs deal passably well with matters of concern, and deeper thought that would put those beliefs in question is eschewed, to protect their stability.

It is through enculturation that we develop a sense of certainty, often mistaking this sense for objective knowing. Health professionals are more attuned to being alert for cultural blindness when interacting with service users from different cultural backgrounds as part of developing cultural competence (Engebretson *et al.* 2008), or the impact of organizational culture on issues such as burnout (Scott *et al.* 2003). The idea that the mental health field is constituted by cultures of care is relatively novel, but has great implications for the way we attempt to understand each other.

Language and culture are intimately connected. Language shapes the very conceptions that a group holds about itself and the world (Kashima & Kashima 1998). The language of psychiatry and mental health expressed and translated into English has a powerful shaping influence on the culture of those who share the language. Over the 20th century, the language of psychiatry and mental health care has taken on an increasingly scientific flavour. This is illustrated well by Bettelheim (1984), a critic of the existing translations of Freud's work into the English language. Freud is often credited in English-speaking circles as attempting to promote a scientific approach to the study of the mind, and the sometimes impersonal language of his theories suggests a detached, unaffected clinical stance in which pathology happens to other people. Bettelheim suggests that Freud's writings in German were compassionate, humanistic, and personal. Freud described psychoanalysis as 'in essence a cure through love' and concerned with matters of the soul

(Bettelheim 1984, p. xi). Bettelheim notes almost all references to the soul (psyche) were excised from the English translations. Despite direct translations for 'das ich und das es' being available (the 'I' and the 'it'), these personal pronouns were translated not into English, but into the Latin (the then language of science and medicine), ego and id, and 'das über-ich' (above I) as the super ego. These are but some of many examples in which Bettelheim demonstrates how highly familiar, personal terms were translated into cold, technical terms with no personal associations, and a highly introspective psychology was made into a scientific behavioural one (in much of the English-speaking world). This agenda to transform psychiatry into a scientific discipline of the same standing as other branches of medicine was firmly on the agenda in North America at the time, and such language served this purpose well (Barton 1987), as language continues to do.

The language of psychiatry tends towards the abstract, impersonal, theoretical, erudite and mechanised, or as Zelan (1993) suggests, 'scientific'. Neophytes entering any of the mental health professions must learn a new language through which to filter and describe deeply personal human experience, thus transforming that experience into scientific constructs or medical problems. Jureidini (2012) notes that in this manner severe shyness has been transformed into social phobia, and problematic behaviour into attention deficit disorder in children. Science is concerned principally with universal truths and experience couched in scientific language connotes some kind of universality. However, deeply personal meaning can be also lost in translation and the language of certainty and universality can obscure difference, culture and context.

This 'loss in translation' applies to discussions about institutions, technologies, health, and illness. Patel (2001, p. 37) notes that diagnostic labels such as depression and phobias have no conceptually equivalent term in many non-European languages. These terms, derived from European cultures, 'have made the leap from common language to medical classification and, in the process, acquired a biomedical significance' (Patel 2001, p. 37). While it might be possible to identify symptoms that cross-cultures, the manifestation or expression of illness or distress tends to be embedded in culture.

Psychiatric classification systems and the language of mental health care are products of Western culture. They have come to be accepted as reflecting universal concepts (and thus, epidemiological data are collected using diagnostic classification systems all around the world). The idea of the universality of mental illness and the universality of treatments are potentially dangerous.

For example, the prognosis of those diagnosed with what is widely considered the more serious and burdensome of illnesses, the schizophrenias, appears better in Africa and East Asia than in Europe and other resource-rich countries (Sam & Moreira 2012). Thus, uncritically exporting Western conceptions and approaches to problems might undermine what has traditionally worked well in these countries. A shared language might also contribute to blindness to difference in other important ways, as an international psychiatric or mental health culture is mutually embedded in local culture and there is often an assumption that the rest of the world might see things in a similar way.

There are endless examples of how articulating and appreciating the cultural context is pivotal to understanding a practice or trend. For example, the DSM is widely criticized as being instrumental in medicalizing everyday life, and many of the categories of disorder as being of questionable validity (Cooper 2005). However, this does not have the same significance in many European socialist health systems, in which diagnosis is not pivotal to receiving services. In contrast, in health systems in which health professionals are often reimbursed for care provided to diagnostic groups (as in the USA) or for the provision of specific interventions (as in primary health care in Australia), diagnosis takes on a particular significance. A person might need to maintain a particular diagnosis (and all that implies) to continue to receive health and welfare services.

For example, in the state of Queensland in Australia, children are diagnosed with Autistic Spectrum Disorder (ASD) at a rate three times the national average, in part because such a diagnosis leads to state-funded teacher assistants not otherwise available to children (Hansen 2010). A survey of child psychiatrists and paediatricians in the state found that 58% of respondents erred on the side of providing an ASD diagnosis when faced with diagnostic uncertainty (Skellern *et al.* 2005). Interestingly, the rate of prescription of stimulant medication in children in Queensland, which requires a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), has been found to be one-quarter that of Western Australia, and the Australian rate of prescription has been found to be up to 11 times that of the UK (Jacobs 2002). Such variations are clearly related to sociocultural factors and funding models for services. A service funding model based on diagnostic related groupings profoundly affects the way professionals view and undertake their work (although rarely are such contextual issues recognized).

There is a presumption of shared understandings and universality of all manner of concepts, including

credentialing of professionals, supervisory structures, and programmes of care and treatment. When reading research about professions or new and successful programmes (and even well-established ideas, such as 'assertive community treatment'), it might be assumed that these products might apply anywhere. This illusion is shattered when one visits different places and experiences different cultures of care first hand. Even the idea of a mental health nurse is enormously problematic, despite it being liberally used as an identifier. Notwithstanding, some argue that it is a myth, misnomer, or aspiration (Barker & Buchanan-Barker 2011), and setting aside the distinction between psychiatric and mental health nursing, there is a huge variation in the preparation, skill set, and context in which nurses practice internationally. The variation is such that one might as well be discussing quite different occupational groups. Some, such as nurses in Ireland, undertake a 4-year honours degree in psychiatric nursing to qualify, but most countries do not have a specialized undergraduate programme for mental health nurses. Indeed, the World Health Organization (2011, p. 52) estimates that, on average, only 3.3% of training for nurses is devoted to mental health-related subjects.

A study on 'clinical supervision in psychiatric nursing' in Denmark (Gonge & Buus 2011) illustrates some of the confusion that can arise by assuming universal understandings of concepts. The sample included registered nurses (not necessarily psychiatric nurses), nurse auxiliaries (no explanation of what these are), and various allied health professionals who worked in a hospital or community centres with 'different professional backgrounds . . . but . . . very similar duties' (p. 102). The supervision intervention (described as reflective practice and some education) was provided by psychiatrists and psychologists in groups. Presumably, to understand this and the positive benefits of supervision that were reported then, one would need to have a shared understanding of what supervision is, what roles nurses assume, and how the supervisory process might inform role development. None of these issues are clear, and indeed, even others in Scandinavia (Råholm *et al.* 2010) have concluded that there are substantial differences in the educational structures, content, and length of nursing programmes in Scandinavian countries such that it is difficult to compare and coordinate programmes to enable graduates to work across even neighbouring countries, let alone Europe and the world. Much literature presumes cultural homogeneity and makes little sense without a rich description of context, and this is often missing in academic discourse.

IMPLICATIONS OF THINKING ABOUT CULTURES OF MENTAL HEALTH CARE

Viewing mental health systems as cultures of care, and mental health practice as embedded in, shaping, and reflecting local culture is potentially liberating. It opens up possibilities to explore and explain how a scientific language has come to predominate in mental health care. Viewing localized communities of practice as being created to meet localized needs, but influenced by the wider psychiatric community, can explain variation in practice, despite shared professional rhetoric.

A cultural view does not eschew a scientific attitude; indeed, it is required to undertake such an analysis. A scientific attitude is a laudable set of characteristics in any clinician, and could be an antidote to scientism. Keating and Duranti (2011) suggest that a scientific attitude is characterized by curiosity, rationality, willingness to suspend judgment, open-mindedness, critical mindedness, objectivity and intellectual honesty, humility, and reverence. Dogmatism and faith-based proclamations appear antithetical to a scientific approach. Yet these persist, and it appears that mental health subcultures seem to accommodate quite different and sometimes seemingly contradictory ideas and positions of members.

There is a rich and varied tapestry of philosophy, theory, and research drawn from a range of disciplines, which have turned their gaze to culture in an attempt to explain it and how it changes. As Patel (2001, p. 35) notes 'cultures are dynamic, complex social constructs which defy easy definition or measurement'. Theories of cultural change are necessarily complex, and in relation to health care, affecting change in a large organization, is likely to take considerable time (perhaps years), be fraught with uncertainty, and involve numerous interlocking strategies (Scott *et al.* 2003). Innumerable lenses, such as discourse (Keating & Duranti 2011), modernization theory (Inglehart & Baker 2000), and information cascade theories (Bikhchandani *et al.* 1992), might be considered to make sense of culture and change. In this paper, I will briefly mention three ideas proposed by Meverson and Martin (1987).

Meverson and Martin (1987) propose that there are at least three paradigms to conceptualize culture and cultural change. Central to these paradigms are different ways of viewing ambiguity, and how differences in understanding are reconciled. The first paradigm stresses shared meanings, rituals, and products that members hold. It stresses consistency, consensus among members, and looks to leaders as cultural creators. Difference is rarely emphasized, ambiguity is rendered invisible, and

radical change occurs through revolutionary processes. This provides an interesting lens, and suggests that leaders have a great deal to do with shaping local cultures, but it does not shed much light on how seemingly irreconcilable ideas can be held within the same group; for example, how personal recovery and service user participation can be reconciled with compulsory or coercive treatment. Indeed, such ambiguities are denied or considered of little relevance.

The second paradigm emphasizes multiple sources of cultural content and diverse subcultures that integrate elements of the dominant culture. The focus of attention is on inconsistencies and differences. Meverson and Martin (1987, p. 633) suggest that subcultures are islands of clarity in a sea of ambiguity. Thus, an inpatient unit might develop a particular localized subculture quite different from the subculture of a community team, but both taking on something of the local culture. Change is incremental, and subcultural change is loosely coupled with changes occurring in the dominant culture. Thus, changes in mental health service cultures might be seen to be influenced by a wider societal embrace of secular, scientific ideas, and consumerism.

The third paradigm acknowledges and accepts ambiguity. Meverson and Martin (1987, p. 637) state that:

A paradigm 3 portrayal of culture cannot be characterised as generally harmonious or full of conflict. Instead, individuals share some viewpoints, disagree about some, and are ignorant of or indifferent to others. Consensus, dissensus, and confusion coexist, making it difficult to draw cultural and subcultural boundaries.

Consistency and consensus are abstract illusions created for the purpose of control. The focus of inquiry is on paradox, hypocrisy, and confusion. Change is constant, and subcultural change stresses 'individual adjustment to environmental fluctuations, including patterns of attention and interpretation' (Meverson & Martin 1987, p. 639). In this paradigm, cultural change comes about through awareness of ambiguity. Thus, for example, the paradoxes and ambiguity highlighted in this paper might subtly serve as a catalyst for change.

What all these paradigmatic ideas about culture have in common is the centrality of language. As Gadamer (1998, p. 389) notes, 'Language is the universal medium in which understanding occurs. Understanding occurs in interpreting'. As described earlier, an uncomplicated way of considering language is to stress shared understandings and consensus. However, language, and indeed practice, is always at least partially localized, and an accurate interpretation requires an understanding of the subcultural

and local context, as well as the grand narrative. For mental health researchers, writers, and practitioners, this means that context is essential to understanding practice. When writing about or sharing a local innovation or practice, a rich description of the context is essential for anyone beyond the immediate horizon to interpret what is really going on. Without such a description, publications might be worse than useless; they might perpetuate or reinforce the illusion that what might work in one place will work in an uncomplicated way elsewhere, or that the same words imply a common understanding.

Fancher (1995, p. 47) suggests that 'At least cultures of care constitute communities of inquiry; something approximating mutual aid and peer review is possible within each culture'. Arguably too, such a view can (and frequently does) accommodate science, and while it reflects a particular culturally-bound value to suggest so, a local mental health practice culture that encourages a genuinely scientific approach is likely to be more helpful than one founded on tradition and authority.

Viewing mental health as cultures of care also moves to centre stage the impact of values. Values, as Rokeach (1973) argued, are the main dependent variables in the study of culture, society, and personality. Indeed, scientism reflects a particular set of values. In mental health, working in a way that supports people towards personal recovery does not involve applying particular models or theories; rather, it involves the enactment of values. In recent years, this has been acknowledged quite explicitly by some authors (Buchanan-Barker & Barker 2008), and indeed, values-based practice has been suggested as an alternative or complementary orientation to EBP in mental health (Woodbridge & Fulford 2004). However, a cultural lens suggests that values are always present, although people may be blind to their own if they are not brought into contrast or conflict with others.

CONCLUSION

In this paper, I have argued that psychiatry, and indeed, the mental health field, is not a science. Inevitably, there might be examples of practices founded on good science, but it is well established in sociology that exceptions do not disprove generalizations (MacIver 1933). The limits of science have long been recognized within psychiatry (Eisenberg 2000). However, in the latter part of the 20th century, and with the emergence of EBM, the extent to which mental health practice is informed by science has been overstated. This is in part due to the scientific or technocratic language that has become the lingua franca of psychiatric diagnosis and mental health care. While

diagnosis is descriptive, it is often mistaken for explanation (Sobo 2012). Much of mental health care is based on faith, assumption, and authority similar to religion, an analogy which also has a long pedigree (Szasz 1973). People crave certainty, and desire miracles. Scientific or evidenced-based mental health care provides an illusion of certainty and the promise of miraculous cures. If one accepts these propositions, then this has wide implications for practitioners, educators, and researchers, as it demands that people are continuously involved in reflecting on assumptions about care and treatment that might otherwise be taken for granted.

Viewing mental health care through a cultural lens is useful to make sense of these conflicting or ambiguous positions. While there may be commonalities between the beliefs, norms, and practices in various settings, there are bound to be variations and differences, which need to be understood. Many clinicians appear to appreciate that effective mental health care requires understanding the cultural context in which an individual lives, as this powerfully shapes the experience of mental health and treatment (Sam & Moreira 2012). In this paper, I argue that understanding practice, innovation, and change requires a similar understanding of cultural context, and this context needs to be foregrounded in any paper or discussion across geographical boundaries. Consideration of cultures of care encourages humility, acknowledges complexity, invites sharing of context, and differences across geographical barriers, and suggests new ways to account for mental health practice and change.

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