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A cross-cultural comparison of British and Pakistani medical students' understanding of schizophrenia

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Abstract

This study aimed to compare British, British Pakistani and Native Pakistani (from Pakistan) medical students' beliefs about the manifestation, causes and cures of schizophrenia, prior to any psychiatric training. A total of 305 participants completed a questionnaire on general beliefs about people with schizophrenia, causal explanations concerning the aetiology of schizophrenia and the role of hospitals and society in treating people with schizophrenia. It was predicted that compared with the British and British Pakistanis, the Pakistanis would have more negative beliefs and attitudes, considering people with schizophrenia to be more dangerous and unpredictable; they were also expected to use more superstitious beliefs to explain the cause of schizophrenia and its symptoms; as well as believe more in seeking help from God and faith healers. There was strong evidence to suggest that Pakistanis possessed more negative beliefs and attitudes about people with schizophrenia, but there was no evidence to indicate that Pakistanis believed more in superstitious causal explanations. Pakistanis were more likely to consider seeking help from faith healers, but not God, compared with British Pakistanis and the British. Results confirm previous European-Asian difference in the understanding of the cause, manifestation and cure of schizophrenia. The impact of traditional and Western cultural influences on British Pakistanis is considered.

Keywords: Cross-cultural; Pakistani; Cause; Cure; Schizophrenia

1. Introduction

There is a growing concern about mental health literacy, which Jorm et al. (1997, p. 183) defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Jorm (2000) found that members of the public from many countries have poor mental health literacy, which could have widespread implications for clinical care, including lack of adherence to evidence-based mental health care and help-seeking behaviours. Jorm et al. (2005a) have followed up this research by examining public beliefs about the causes and risk factors for mental disorders, as well as the helpfulness of specific interventions for depression and schizophrenia (Jorm et al., 2005b). Others, in developing countries, have also become interested in the concept (Mubbashar and Farooq, 2001).

Studies in Europe have emphasised the public's poor understanding of schizophrenia, which is commonly equated with a "split personality" (Angermeyer and Matschinger, 1999). Angermeyer et al. (1999) argued that public opinion has a direct effect on the individuals suffering from the mental disorder, as they themselves

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adopt public beliefs in the process of socialisation. This emphasises the need to understand the belief systems of the general public regarding schizophrenia, as well as those in the medical profession.

Various studies have examined the public's beliefs about schizophrenia (Furnham and Bower, 1992). Dietrich et al. (2004) found a positive relationship between causal beliefs emphasizing biology and increased social distance towards people with schizophrenia and depression in four cultural groups. They hypothesised that this may be due to the perception that biological causation or "brain disease" implies a lack of cognitive control on the part of the patient. Therefore, the public may believe that people with schizophrenia are "dangerous and unpredictable" and this could result in the desire for increased social distance.

Various cross-cultural studies have demonstrated that there are national cultural differences in how people respond to mental illness. Furnham and Murao (1999) described marked differences between British and Japanese attitudes towards people with schizophrenia. The Japanese were more concerned about contact with people with schizophrenia and believed that mental hospitals were the best place for them. The British held more positive attitudes towards people with schizophrenia, and believed them to be less dangerous and abnormal than Japanese respondents did. Furthermore, the British were more concerned about patients' rights and did not believe in keeping them confined in mental hospitals. Furnham and Chan (2004) in a British–Chinese comparison concluded that Chinese people were more likely to believe that people with schizophrenia are "dangerous, uncontrollable and act abnormally". Knowledge about schizophrenia and having friends with mental disorders was associated with a more positive attitude towards people with schizophrenia. The Chinese and British differed in their beliefs regarding the causation of schizophrenia; the British relied more on *biological* models, whereas the Chinese believed in *social–environmental* models. Furnham and Wong (2007) found a Chinese population of young people compared with a British equivalent group held more religious and superstitious beliefs about the cause of schizophrenia, while the British stressed biological, psychological and sociological explanations. Further, as predicted, the Chinese seemed to have less positive attitudes toward people with schizophrenia in general compared with the British.

Jablensky (2000) noted that schizophrenia has a more favourable course in developing, than developed, countries. A higher proportion of patients were in remission in developing countries and fewer patients suffered from impaired social functioning. Although the reason for the better outcome in developing countries is essentially unknown, the family structure in developing countries may account for this. Family networks are broader and closer, and no individual member is expected to have sole responsibility for the care of the person with schizophrenia.

Furnham and Malik (1994) suggested that in many Asian cultures in the sub-continent, the family interest comes before individual interest, and illnesses such as depression may not be tolerated well, as they may be regarded as "self-indulgent". Therefore, they proposed that the consequences of mental illness may be more serious in such cultures, where mental illness of one family member can have detrimental effects on the reputation of the whole family. Signs of mental health problems may be ignored by the patient and the patient's family, resulting in a delay in seeking professional help.

Razali et al. (1996) found that supernatural explanations, such as witchcraft and possession by evil spirits, are often used in non-Western cultures to explain the aetiology of mental disorders, but this is not common in the West (Angermeyer and Matschinger, 1999). Rack (1982) noted that magical and supernatural explanations are often put forward by Pakistanis as a cause of mental illnesses. Patients may wear a protective charm called a "Tavees", which may constitute holy verses from the Quran, and is used as a defence mechanism against witchcraft.

This study compares the beliefs of three groups of third-year medical students: British, Pakistani and British Pakistani students before they had taken a course in psychiatry. There are conspicuous social, cultural and religious disparities between Britain and Pakistan in the way the media portrays information on mental health issues. This no doubt, in part, creates differences in both the public's perception of mental health disorders and education about them. Strong religious beliefs and differences in the structure of the health care system may affect attitudes towards help-seeking behaviours. The health care system in Pakistan is medically pluralistic, which is typical of the Indo-subcontinent (Leslie, 1976). The main mental health service providers include orthodox psychiatric services as well as the traditional faith healers and hakims (Saeed et al., 2000). Most doctors work in cities and overall there is 1 doctor per 10 000 of the population. In rural areas, where the literacy rates are poor and there is a lack of modern health facilities, faith healers may be the only source of treatment. Faith healers may be considered to be more useful in treating emotional problems even if modern health facilities are available (Saeed et al., 2000). However, use of faith healers is not necessarily related to having a personal religious commitment. It is more likely to be related to cultural beliefs about mental illness (Kakar, 1982). Tabassum et al. (2000) reported that treatment expectations of Pakistanis living in