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A Fallacy of the World Health Organization's Mental Health Gap Action Programme and Intervention Guide: Counseling and Psychotherapy Are Also (Western) Indigenous/Traditional Healing Methods

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This article will argue that, rather than being objective and universal treatment approaches, counseling and psychotherapy are indigenous/traditional (i.e., cultural) healing methods of the Euro-American West. Therefore, the World Health Organization's Mental Health Gap Action Programme (MHGAP), designed to provide increased access to reportedly highly effective Western mental health treatment services in many low- and middle-income countries, is likely to falter. It can be argued that culturally adapted counseling and psychotherapy will be most effective for individuals in non-Western countries who endorse or are somewhat acculturated to Western understandings and ways of living. Therefore, Western psychological interventions should not be at the forefront of the MHGAP in non-Western countries. Supportive evidence for this perspective is summarized and alternative approaches to promoting global mental health that draw on non-Western indigenous healing practices are presented.

Keywords: indigenous healing; traditional healers; contextual model; World Health Organization; Mental Health Gap Action Programme; global mental health

Despite dissent (e.g., Bedi, 2018), counseling, psychotherapy, and Western psychological treatments have gained reputation as evidence-based aids for promoting positive mental health outcomes worldwide (World Health Organization [WHO], 2008). It can be argued (based on a plethora of evidence) that counseling and psychotherapy are culturally encapsulated practices (Wrenn, 1962) rather than universally valid and effective healing traditions. As argued elsewhere (e.g., Wampold, 2001), counseling and psychotherapy were developed within Western assumptions and mores for resolving complaints highly pertinent to Western individuals in a matter consistent with dominant Western worldviews. Therefore, these practices can be conceptualized as indigenous[1] mental health treatment practices of the Euro-American West that demonstrate conceptual overlap with indigenous healing practices all across the world (Frank & Frank, 1993).

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When viewed this way, the potential problems with exporting and judiciously applying counseling and psychotherapy globally (see Hohenshil et al., 2013; Moodley et al., 2013; Stanard, 2013) should become more apparent (for a poignant example of problems, please see Christopher et al., 2014).

The purpose of this article is to argue that a fruitful integration of Western and Non-Western healing practices is possible under specific conditions and should be prioritized by the WHO's (2008; 2015) Mental Health Gap Action Programme (MHGAP) in a manner that is very different from what is currently being promoted. Specifically, it is proposed that indigenous healing practices may best benefit from some culturally adapted Western counseling and psychotherapy (CAWCP) and psychological interventions, particularly if they are delivered within the indigenous healing medium by traditional healers, for those who are less acculturated to Western ways of thinking and behaving. In other words, counseling and psychotherapy's global relevance depends on consistency between Western and specific non-Western cultural, intellectual, and moral traditions. This is especially true about theories of mental distress etiology and cure, with degree of effectiveness seemingly also hinging on variables such as acculturation to Western culture and non-Western ethnic identity. These perspectives are not carefully considered in the ever popular WHO's (2008, 2015) MHGAP and its Intervention Guide (WHO, 2016).

In this article, we explicate two underlying principles. First, there is great benefit by an integration of indigenous healing with CAWCP that prioritizes local healing traditions and cultural context. Second, traditional healers are a vital source for which to transport potentially helpful Western psychological interventions, if they are deemed in advance to be culturally congruent and beneficial to the local culture by those indigenous to the culture (see Bedi, 2018). Because the exportation of Western methods of healing (e.g., psychotherapeutic interventions) is a central part of the WHO's (2008, 2015) MHGAP as part of its push for global mental health, we will first examine this program in more detail to provide some context for our arguments. In promoting integration between CAWCP and indigenous healing, we will endorse avenues that are quite contrary to widely accepted beliefs in the global mental health movement (see Patel, 2012) and those employed within MHGAP. For example, we will advance the unorthodox view that a Western evidence base should not be the primary reason for implementing a particular Western psychological intervention in a non-Western country. Rather, the intervention should have consistency with local cultural beliefs and well-utilized traditional healing practices, as judged primarily by the recipients of the exportation.

GLOBAL MENTAL HEALTH AND THE GLOBAL MENTAL HEALTH MOVEMENT

In 2007, leading medical journal *The Lancet* published a special issue called *Global Mental Health*, which helped shift attention toward the lack of access to Western mental health treatments in low- and middle-income (LMI) countries (The Lancet, 2007). As part of the global mental health movement, disability-adjusted life year (DALY) became popular for examining mental health policy in an international context. The DALY is a metric looking at the contribution of a disorder/disease to disability and mortality (Desjarlais et al., 1995). "One DALY can be thought of as one lost year of 'healthy' life. The sum of these DALYs

across a population, also called the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability" (WHO, 2014, para. 1). The DALY allows for the quantification of the negative impacts of mental health on disability and mortality (Prince et al., 2007). Whiteford et al. (2013) found that in 2010, mental and substance use disorders accounted for 7.4% of all DALYs globally, implying that mental health plays a significant role in one's life expectancy and quality of life. This global figure of 7.4% represents an increase of nearly 40% between 1990 and 2010, suggesting a rising need for mental health services (Whiteford et al., 2013).

On a global scale, it is estimated that 75%–90% of individuals in the world can benefit from clinical mental health treatment (defined primarily in terms of standard biomedical psychiatric and Western psychological services) but do not receive it (Chisholm et al., 2016; Kohn et al., 2004). This is called the treatment gap and it can be defined as the absolute difference between the prevalence of mental illness, as conceptualized in Western countries, and the proportion of the population treated (Srivastava et al., 2016), with treatment being defined implicitly as the dominant Western treatments. These figures are used to justify the creation of the WHO's MHGAP and propel its expansion.

The WHO's Mental Health Gap Action Programme

The WHO's (2008, 2015) MHGAP aims to eliminate mental health disparities and the treatment gap by scaling access and creating affordability to mental health treatments (typically psychiatric medication and Western psychological treatments) globally in LMI countries. For example, the MHGAP promotes the use of antidepressants as a standard treatment for clinical depression (WHO, 2016). The intention, often defined as an act of social justice, is to ensure that individuals around the world experience equal access and benefit from counseling, psychotherapy, psychiatric medication, and other such Western mental health treatments approaches promoted as evidence based within a Western framework (WHO, 2015). Presently, the program spans over 90 countries and materials for the program have been translated into over 20 different languages (WHO, 2016).

The MHGAP has received strong praise from large mental health organizations such as the American Psychological Association (Clinton, 2018). As concluded by a recent systematic review, the evidence base for the components within the MHGAP Intervention Guide is surprisingly light and dominated by research done in only a small handful of countries (Keyneajad et al., 2018). The demonstrated ability of the MHGAP to reduce mental health stigmatization, one of its secondary aims, is also on shaky empirical ground (see systematic review of Heim et al., 2018).

As a case in point, India's mental health treatment gap, defined in the manner noted above using DALY, is estimated to be 76%–85% (Demyttenaere et al., 2004). One of the reasons for this extreme gap has been reported to be the lack of infrastructure for conventional (Western) mental health services (Strivastava et al., 2016; Thirunavaukarasu, 2011). For example, the country severely lacks mental health workers such as psychologists, psychiatrists, and psychiatric nurses, most of whom are typically concentrated in urban areas with more Westernized health treatment facilities (e.g., hospitals, Patel, 2012). This deficit encouraged the MHGAP to take on a task-shifting approach and train nonspecialist community health workers, and even lay members of the community, to provide frontline mental health intervention in India (Patel et al., 2011). These interventions often occur

outside of the confines of a typical counseling and psychotherapy session, as observed in Western countries (e.g., counseling office), such as at the home of the client or out in the community in the presence of significant others (Patel et al., 2011).

Despite these adaptations, psychological interventions in India and other LMI countries are often still premised on Western norms as evidenced by (a) the mass of individually focused interventions (vs. familial or group interventions, which may be preferred or more appropriate in collectivistic cultures such as India; Triandis, 1995); and (b) the lack of incorporation of traditional Indian healing methods within the MHGAP (Singla et al., 2017). There is also meta-analytical evidence indicating that the effect size of these psychological interventions in non-Western countries is noticeably lower than the same psychological treatments applied in Western countries (Singla et al., 2017).

Conventional counseling and psychotherapy practices, as well as CAWCP, are commonly promoted for use in non-Western countries with individuals who are less Westernized, within the purview of the MHGAP (George & Pothan, 2013; WHO, 2016). These now globalized practices have received growing criticism among a rising set of dissenting voices (e.g., Bedi, 2018; Bemme & D'souza, 2014). An obvious criticism is that the proponents of the MHGAP are imposing their own culture's healing practices (noting the dominance of Western authority in the WHO) over indigenous healing methods, even though traditional methods have worked successfully for overcoming mental distress much longer than the existence of the practices of Western counseling and psychotherapy (Nortje et al., 2016; Waldram, 2000, 2013).

In addition, there may be larger consequences to displacing long-standing traditional healing practices which are deeply woven within the fabric of a national culture's mentality, and these consequences are not given due attention by the WHO or its MHGAP. For example, discrediting traditional healers could iatrogenically create conflicts and perhaps engender new psychospiritual/existential issues and associated mental distress (Bedi, 2018; Christopher et al., 2014). As another example, in India, perhaps the welcoming of and apparent benefits of Western interventions in India can partially be accounted for by the presence of a colonial mentality shaped by British rule prior to India's independence in 1947 (Cohn, 1996). In a colonial mentality, the historically oppressed individuals internalize an attitude of cultural inferiority and attempt to identify with the group in power uncritically and as much as possible, sometimes to gain status within their own communities (Adams et al., 2015).

Other processes that could partly explain the widespread expansion of the MHGAP and its Western methods globally relate to the potential imposition of Western cultural and political interests on the East for national or entrepreneurial gain (Marsella, 2009). For example, pharmaceutical companies have an immensely profitable stake in having mental disorders defined in biochemical terms treatable by psychiatric medications (Summerfield, 2012). A case could also be made for cultural imperialism by the more powerful and well-resourced West (Rothkopf, 1997). In cultural imperialism, due to power imbalance and a privilege advantage, a particular culture promotes or imposes its own culture on a less powerful nation or society, holding up its own culture as the gold standard and denigrating alternatives. For example, the individualism inherent in many Western nations stands in stark contrast to the collectivism more prevalent in many non-Western countries such as India (HBD Chick, 2013). Therefore, it should come as no surprise, for example, that marriages arranged by family or elders, while still being the norm in many countries such as India, are often marginalized by those in Western countries in comparison to individual

choice marriages (Bedi & Rogers, 2016; Cardona et al., 2019). Nevertheless, even if we assume that Western treatment methods are unconditionally superior in effectiveness, an ethical argument could still be made about the importance of protecting the autonomy of a country to solve its own problems (with solutions congruent with its cultural context) over (a) the possible beneficence of Western treatment approaches and (b) potentially doing harm culturally by estranging traditional healers (Shah, 2012). There are also other criticisms toward the foundation of which the MHGAP program is based, particularly, that it and the current manifestation of globalization is based on special interests and perhaps an ideology of White Supremacy (Allen, 2001), which exert influence on the WHO, rather than true social justice (e.g., see Bedi, 2018). If there is validity to some of these critiques, they would serve as clear barriers to the WHO accepting the premises and guidance provided in this article.

Nevertheless, and despite the above-stated criticisms, the unprecedented vigorous push to scale up mental health resources globally by the WHO has led the MHGAP to face many major challenges such as the following (Eaton et al., 2011; Saraceno et al., 2007):

1. The difficulty in integrating mental health care into primary care settings such as hospitals.
2. An immense lack of trained mental health personnel (i.e., trained in Western methods).
3. Many of the world's citizens still consult traditional healers, usually as their first and sometimes only therapeutic contact.

A relatively recent shift is occurring within the MHGAP to address these failures, where there is greater interest developing in soliciting traditional healers. However, while seemingly innovative and presented in the spirit of collaboration, these efforts usually involve trying to convince (and sometimes impose on) traditional healers to work within Western understandings (e.g., the MHGAP Intervention Guide is premised on the WHO's International Classification of Diseases). Often there is usually no more than an attitude of inevitable accommodation because the use of traditional healers persists in high numbers, despite the MHGAP's best efforts to impose Western methods of healing (e.g., Uwakwe & Otakpor, 2014). What could be called an underlying arrogance or pompous pretentiousness among those promoting the MHGAP globally is rarely recognized (Mills & Hilberg, 2019). However, this could perhaps be better highlighted by asking individuals in the West what it would take for those in the West to convince Western individuals to partake in alternative non-Western healing practices at the expense of Western treatments for physical and mental disorders.[2] Fortunately, a framework exists that can equate Western medical and indigenous methods of mental healing and promote a more respectful integration.

THE MEDICAL AND CONTEXTUAL MODELS OF COUNSELING AND PSYCHOTHERAPY

The MHGAP is premised upon a Western medical model of mental health disorder causality and treatment, with the latter including (but not limited to) counseling, psychotherapy, and Western psychological interventions. It is established, via an abundance of research, that counseling and psychotherapy work well across most mental health issues facing the Western world (primarily North America and Europe). Smith et al. (1980) have found an effect size of 0.68 on the efficacy of counseling and psychotherapy, meaning the average

clients are better off than 75% of individuals who did not receive such services, and this has been further replicated with more recent, comparable meta-analyses (de Jong & DeRubeis, 2018). It is important to note that these mental health issues are theorized, defined, and researched from within a Western worldview and that evidence from outside of this ontological and epistemological stance is scarce, if it even exists (Henrich et al., 2010).

The practices of counseling and psychotherapy presently is dominated by the medical diagnose-and-treatment paradigm (Elkins, 2009). As outlined by Wampold and Imel (2015), in this medical model, a client presents symptoms that manifest an underlying psychopathology or clinical problem (e.g., clinical depression). The professional has to diagnose the underlying psychopathology/problem and then promotes a psychological explanation for the underlying issue (e.g., maladaptive thinking and irrational beliefs). The professional then applies a particular psychological intervention or interventions that address the promoted mechanism of change undergirding the provided psychological explanation for the disorder (e.g., cognitive therapy), and it is presumed that the specific techniques employed (e.g., identifying and modifying cognitive distortions) are reasonably specific to the disorder under treatment and cannot haphazardly be applied to any psychological condition with positive results.

However, in line with the contextual model of counseling and psychotherapy (Wampold & Imel, 2015), some oft-neglected but large body of research suggests (a) counseling and psychotherapy are forms of healing that are unique to the West, rather than universally valid practices, and (b) counseling and psychotherapy share important therapeutic systems and structures with all well-established indigenous healing approaches across the world (Frank & Frank, 1993; Havenaar, 1990; Kakar, 1982; Kleinman & Seeman, 1998). Thus, there are both surface differences and underlying similarities between Western CAWCP and indigenous healing methods across the world. The contextual model of counseling and psychotherapy emerges as a viable alternative to the strict medical paradigm of CAWCP sweeping the Western world and undergirding the MHGAP.

According to the contextual model of healing as espoused by Frank and Frank (1993), which is incorporated within Wampold and Imel's (2015) contextual model of psychotherapy, counseling and psychotherapy are the culturally congruent responses of the West to the mental health problems endemic in the Western world (Triandis, 1995). The following four shared factors are identified as giving both counseling/psychotherapy and other indigenous healing methods a large part of their potency:

1. A culturally approved healing setting, such as a counseling office or temple.
2. A trusting and confiding relationship with the healer, such as a therapeutic alliance with a counsellor or emotional attachment to a spiritual healer.
3. A therapeutic rationale and conceptual framework that provides an explanation for the individual's presenting complaint, and justification for the efficacy of the proposed methods, such as a psychotherapeutic approach like cognitive behavioral theory or the scriptures contained within some holy book. This explanation must be plausible within the broader cultural context and within the individual's belief structure.
4. Rituals/procedures (i.e., proposed mechanisms of change) that logically flow from the therapeutic rationale, such as specific psychotherapy procedures, religious rituals, or yoga practices. The specific counseling and psychotherapy techniques (or indigenous healing rituals) are not as important as the engagement of the individual and the healer through shared understanding and affective mutuality (Frank & Frank, 1993).

The contextual model can account for why major psychotherapeutic theories in the West appear to have similar degrees of efficacy on average, even if the theories have contradictory rationales for the same disorder (Wampold & Imel, 2015). The contextual model can also explain why individuals residing in Western countries who are recent immigrants or racial/ethnic/cultural minorities do not achieve as much benefit from counseling and psychotherapy as individuals of the dominant Euro-American Western majority culture (Dobalian, & Rivers, 2008; Imel et al., 2011; Owen et al., 2012). In fact, it is the opinion of the present authors and others (e.g., Wampold & Imel, 2015) that the abundance of research evidence from North America and Europe is more consistent with the contextual model over the medical model of counseling and psychotherapy and that the latter is promoted for reasons other than those solely based on indisputable evidence.

The contextual model has recently gained in popularity on the shoulders of an abundance of extant research highly consistent with the model (Wampold & Imel, 2015). Only recently has research focused on directly testing the model. For example, a meta-analysis by Benish et al. (2011) found that CAWCP produced superior outcomes over conventional counseling and psychotherapy, but cultural adaptations related to explaining the treatment within the client's cultural framework accounted for almost all of CAWCP's incremental efficacy. In other words, explaining the cause of the disorder and proposed mechanisms of cure within a culturally congruent framework accounted for most of the benefit of CAWCP. Another meta-analysis by Xu and Tracey (2016) found that in China, the efficacy of psychotherapy varied by the degree to which theoretical orientations employed were consistent with traditional Chinese healing methods and Chinese cultural explanations of psychological distress. In support of the contextual model, both meta-analyses suggest psychotherapy that is most culturally congruent with the client will be the most successful (Benish et al., 2011; Xu & Tracey, 2016).

APPROPRIATE IMPLEMENTATION OF CAWCP

Noting that Western influence continues to spread on a global scale, CAWCP and Western psychological interventions will be effective to the extent that a country's culture has parallel cultural structures with Western ones. Even within a non-Western country, between-person differences should appear, depending on an individual person's extent of adherence to mainstream Western norms and values. Therefore, an individual's ethnic identity development and level of acculturation to Westernization should be considered prior to implementing CAWCP and Western therapeutic modalities with a particular individual both, in the West and abroad (Bedi, 2018; Berry, 1997; Rudmin, 2003).

Below, we provide three alternatives to the conventional push for CAWCP in non-Western countries that can help tackle some of the major challenges identified by proponents of the MHGAP itself (noted earlier) and potentially reduce the mental health treatment gap and mental disorder burden as defined by advocates of the MHGAP. We note that our proposals are less disempowering and more respectful of traditional healers and indigenous healing practices still popular in most of the world today (also see Bedi, 2018).

Alternative 1: Focusing on Pre-Existing Cultural Congruence of Current Western Methods

The meta-analysis by Benish et al. (2011) found that cultural adaptations explaining the psychological benefits of the intervention within existing cultural frameworks had accounted for almost all of CAWCP's efficacy. Thus, we could start by researching the cultural beliefs of a given country to understand where cultural congruence lies, implementing Western theories and mental health treatment practices that are already mostly consistent with existing indigenous healing practices (Bedi, 2018; Sandhu, 2004). Here, Western practitioners can offer (or train locals to offer) culturally congruent therapies or psychological interventions that should have a higher chance of success than other therapies (Wampold & Imel, 2015). For example, Sandhu (2004) promoted existential counseling and psychotherapy as highly consistent with the tenets of the Guru Granth Sahib (the Sikh religion's holy scriptures) and therefore elements of it would be expected to be a better fit for adaptation to the state of Punjab in India, which is primarily comprised of followers of the Sikh religion. This alternative should only be implemented if the indigenous healing methods in place are not working, as defined by the locals themselves (Bedi, 2018), and if they show receptiveness to alternatives.

Alternative 2: Collaboration With Traditional Healers as Equals

There are many clear challenges to equally footed collaboration between Western healers (i.e., psychiatrists, psychologists) and traditional healers and between Western mental health treatment methods and indigenous mental healing methods (Bojuwoye & Sodi, 2010). Both perspectives must be deemed comparably valuable with the efficacy superiority of each depending on the particular individual being treated; and differing for each individual. In this collaborative framework, the client has exposure to both therapeutic frameworks (Western and local indigenous) and is in the position to work with the healer/treatment professional of choice or both such that neither is deemed universally more superior. Both are communicated as effective options and both the Western healer and the traditional healer can collaborate as part of an overall treatment team.

Alternative 3: Using Traditional Healers to Provide Culturally Congruent Psychological Interventions

Following the task-shifting approach (Patel, 2012), psychological interventions can be largely carried out within existing indigenous healing practices by the traditional healers themselves, if the Western psychological approach is deemed consistent with and complementary to the indigenous healing practice by the traditional healers. In this alternative, traditional healers remain the primary vehicle of mental health treatment, but they can be trained to incorporate Western psychotherapeutic interventions into their own traditional healing practice in a manner similar to assimilative integration (Lampropoulos, 2001; Quah, 2003). Implementing this alternative would require the WHO MHGAP to be open to alternative cultural explanations, customs, and rituals without superseding them with Western therapeutic explanations and modalities. The ultimate goal should be the individual reporting satisfaction and symptom reduction or remittance, regardless of whether or not the WHO endorses the psychospiritual explanation provided by the traditional healer or the healer's indigenous methods. In this alternative, Western explanations and interventions will supplement and not supplant local indigenous

healing practices, which will remain central (Bedi, 2018). This pathway is an especially practical approach to dealing with the MHGAP proponents' identified barriers: (a) the problems of overcentralization of mental health resources in larger cities, as decentralizing the training to target indigenous healers can mitigate overcentralization; (b) problems of integrating mental health in primary care settings such as hospitals, since now evidence-supported primary care can be integrated outside of the medical setting and reach greater people; and (c) the need to increase the number of "trained" mental health workers. This alternative will further provide indigenous healers a two-way global platform for sharing effective indigenous therapeutic techniques practiced today, with those in the West.

CONCLUSION

In conclusion, if one accepts the rhetoric of the treatment gap, the WHO's (2008, 2015) MHGAP is an ambitious attempt at closing the mental health treatment gap around the world. However, through the lens of the contextual model, it is doomed to fail in eliminating disparities in DALY unless its proponents recognize (a) counseling and psychotherapy, even when culturally adapted (Bedi, 2018; Bernal et al., 2009; Griner & Smith, 2006) are culturally constrained (not universally applicable) healing practices, and (b) traditional healers and indigenous healing practices can be quite beneficial in their own right and through integration with Western methods and healers, in which the former (indigenous methods) remain primary. In this article, we provided rationales for three alternative solutions to more successfully integrate Western therapeutic modalities with indigenous healing methods, and improve the outcomes of the MHGAP more specifically, and the mental health of the world's populace, more generally.

NOTE

1. By indigenous, we are not meaning the common portrayal in Western psychology as referencing the early inhabitants of a Western country in contrast to groups that have subsequently settled, occupied, or colonized the area. Therefore, we are not referring to who are commonly called "Native Americans," "First Nations" peoples, or "Aboriginals." Instead, we are using the term in a broader, anthropological sense. By "indigenous" we are specifically referring to culturally native or traditional prior to Western Euro-American (or other modern colonizing force's) dominant influence. In other words, we are seeking to describe a geographically constrained ancestral group of individuals united by common culture and sense of kinship. Therefore, for example, the cultural practices of those living in India prior to the colonizing cultural changes attributed to the British invasion and subsequent globalization would be considered "indigenous" to India.
2. For a philosophical analysis exploring the historical and moral forces that legitimize the MHGAP, the reader is referred to Mills and Hilberg, 2019.

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