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Psychiatry and Bureaucratic Obstacles in Non-western and Western Countries

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Abstract: This article examines the role of bureaucratic structures in psychiatry and psychology across Western and non-Western contexts, with a particular focus on how legal, institutional, and cultural factors shape access to mental healthcare. Drawing on empirical insights from intercultural psychiatric practice in the Netherlands and a detailed institutional analysis of India, the study conceptualises mental health systems as complex configurations of medical, administrative, and socio-legal arrangements rather than purely clinical entities. The analysis demonstrates that bureaucratic obstacles emerge through multiple mechanisms, including regulatory frameworks, professional licensing systems, fragmented service provision, and funding structures. In non-Western contexts, these challenges are further compounded by cultural stigma, plural medical traditions, and collective decision-making norms. Using India as a case study, the article traces the historical evolution of psychiatric bureaucracy from colonial asylum systems to contemporary rights-based governance under the Mental Healthcare Act (2017), highlighting the coexistence of biomedical and traditional systems within a dual-track administrative model. The article argues that mental health outcomes cannot be understood without considering the interaction between bureaucracy, culture, and broader social determinants such as education, employment, and social inclusion. It further presents intercultural, socially embedded models of care as a promising alternative to standardised bureaucratic approaches. The study concludes that improving mental healthcare requires not only clinical innovation but also institutional reform, cultural competence, and the reduction of bureaucratic barriers, particularly for migrant and marginalised populations

Keywords: Psychiatry, Psychology, Bureaucracy, Mental Health Systems, India, Intercultural Psychiatry, Migrant Mental Health, Social Determinants of Mental Health, Mental Health Policy, Mental Healthcare Act 2017, National Mental Health Programme, Rehabilitation Council of India, Institutional Psychiatry, Cultural Competence, Structural Inequality, Bureaucratic Obstacles, Global Mental Health, Peace and Conflict Studies, Social Inclusion, Transcultural Mental Health.

INTRODUCTION AND INTRAETHNIC MENTAL HEALTH METHODOLOGY

The following article (Steinmetz et al. 2012) examines the intercultural mental-health methodology developed by AlleKleur, an Amsterdam-based intraethnic mental-health organisation specialising in care for migrant populations. Drawing on clinical practice, community-based interventions, and empirical research among Turkish-Dutch clients, the authors argue that conventional Dutch psychiatric and psychosocial services insufficiently address the lived realities, cultural frameworks, and structural disadvantages faced by migrants.

As presented in this article, mood and anxiety disorders occur more frequently among migrant communities, often linked to socio-economic precarity, migration stressors, and experiences of exclusion. AlleKleur responds to these patterns through its integrated working model, the **Socially Embedded Method**, which combines psychiatric treatment with practical assistance in the domains of education, employment, neighbourhood participation, and language acquisition (pp. 15–16).

A central component of this model is therapy delivered in clients' **mother tongues**, justified by the view that emotional expression—and particularly the capacity to process trauma—is deeply embedded in one's first language. The organisation therefore employs multilingual psychologists and social workers, enabling culturally grounded therapeutic relationships. This article notes that this approach contrasts with mainstream Dutch mental-health institutions, which often prioritise standardised professional protocols over culturally embedded care.

The empirical research described in the article focuses primarily on **Turkish clients** (n = 50) in Amsterdam, the Netherlands. Conducted through structured interviews and observations, the study explores clients' needs, treatment experiences, socio-educational barriers, and aspirations for integration. The findings demonstrate persistent challenges in areas such as Dutch language acquisition, vocational training, and educational trajectories for both adults and children (pp. 16–17). Many clients report limited access to Dutch social networks, with notable ambivalence between maintaining cultural identity and pursuing social mobility within Dutch society.

The article also documents clients' strong interest in volunteer work, employment opportunities, and community participation, revealing that a substantial proportion express a desire to contribute actively to Dutch society (p. 18). However, institutional barriers—especially within the labour market—continue to impede these efforts. AlleKleur's response includes facilitating volunteer placements, providing guidance toward education and work, and building bridges between migrant communities and local Dutch institutions.

The authors conclude that culturally responsive care, delivered in clients' native languages and embedded in their social contexts, is essential for addressing the psychological and structural dimensions of migrant wellbeing. The study highlights the need for integrated, intercultural, and community-oriented interventions that move beyond clinical symptom treatment toward supporting migrants' broader participation in society. The findings position AlleKleur's approach as both a therapeutic model and a social-justice project aimed at countering exclusion, promoting empowerment, and enhancing long-term health and integration outcomes (pp. 18–19).

It is not just AlleKleur who has observed that a person's psychological and spiritual well-being is influenced by environmental factors. In the United States, Shim (2028) came to a similar conclusion, which is in line with the findings of other studies.

> *"When considering how social determinants influence health, Shim (2018) said, the "ultimate marker of health" is mortality. There are a number of factors that influence a person's likelihood of premature mortality, including genetic predisposition, behavioural patterns, health care, environmental exposures, and social circumstances. However, Shim said, nearly all of these factors are ultimately related to social determinants.*

Exposure to environmental toxins depends in large part on the neighbourhood in which a person lives and on the availability and affordability of safe housing. Whether a person has access to high-quality health care depends on income, insurance, and proximity to high-quality facilities. Behavioural patterns—such as exercise, diet, and smoking—are influenced by such factors as the availability of healthy foods and access to a safe place to exercise. Even genetic predisposition can be influenced by social determinants; for example, trauma experienced by parents and grandparents may change the genetic and epigenetic makeup of their descendants. While some of these determinants may be due in part to individual choices, Shim said, "the choices we make are based on the choices we have." People who have limited options are less likely to be able to make good choices."

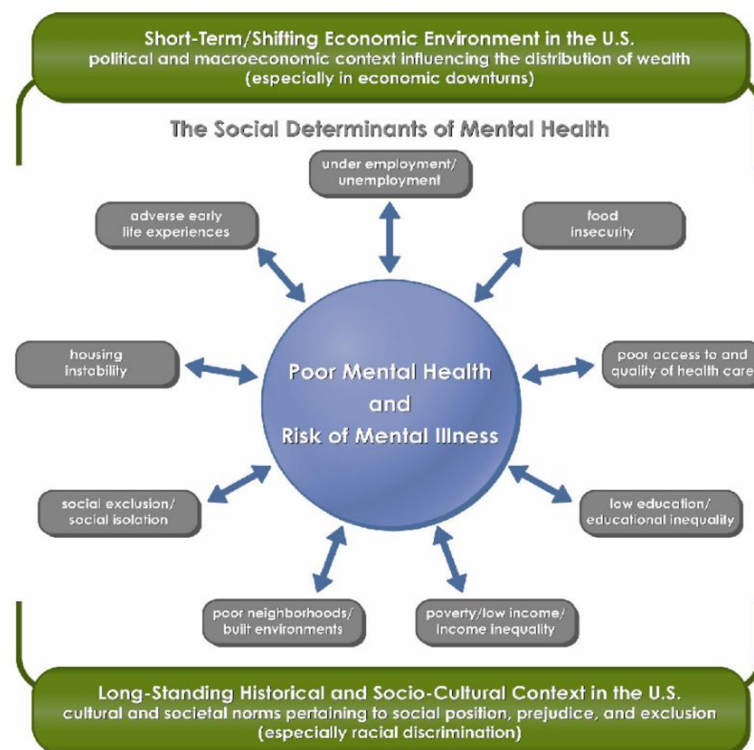


Figure 1: The Social Determinants of Mental Health: An Overview and Call to Action (https://ap.lc/TXVaV)

Professor Dr. Jim van Os (2026) in Utrecht, the Netherlands furthermore clearly supports AlleKleur's argument:

"'Diagnoses such as depression, psychosis or ADHD do not always help people,' he says. According to Professor van Os, we should therefore stop thinking in terms of labels. In order to move forward, we need to consider what individuals require. He set out his views in an opinion piece published in the renowned scientific journal Nature this week.

For more than seventy years, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has been the international handbook for psychiatric

diagnoses. The American Psychiatric Association is now working on a new version. It should be more precise, paying more attention to biological characteristics and including additional categories.

However, Jim van Os, a professor of psychiatry at UMC Utrecht and chair of the Brain Division, believes this is not the solution. "We have gathered a lot of knowledge. Yet we know that psychiatric labels tell us little about how someone is really doing. They do not help us to provide better care."

Start with questions.

In many wealthy countries, around one in four people will receive a psychiatric diagnosis at some point in their lives. However, such a label does not reveal the cause of sadness, anxiety, or despair. Nor does a diagnosis say much about what kind of help someone needs. Two people with the same diagnosis may have very different lives and require different things.

"Mental suffering is poorly captured in symptom lists and labels," says Jim van Os. "It's time to stop diagnosing and start asking questions: What is happening here, and how can we help this person move forward?' Van Os no longer wants to start with a psychiatric label. He wants to consider what is really happening in someone's life first. According to him, people experiencing mental distress often become stuck in a pattern. They feel trapped and see no way out. This can manifest as depression, addiction, or psychosis. However, the core issue is often the same: someone is stuck.

Therefore, the most important question is not 'What disorder is this?' Rather, it is: 'What has happened in their life?' What are they good at? What are they sensitive to? What is important to them? Who can help?

Van Os wants a system in which a diagnosis no longer indicates a 'fault'. Instead, it should be clear what kind of support would help someone regain control of their life.

Six regions in the Netherlands are already working with this approach. This approach is being implemented within the Mental Health Ecosystem (GEM) model, in which Van Os is involved. People can choose the kind of support that suits them best. This can be within or outside of mental healthcare. Examples include recovery academies, self-management centres, peer support groups, and online communities. Mental healthcare providers are working differently to how they did before[1]."

INTEGRATING THE ALLEKLEUR STUDY INTO A BROADER FRAMEWORK OF PEACE AND CONFLICT

The 2012 article on **intercultural mental-health provision at AlleKleur** provides a micro-level empirical foundation that complements and reinforces the macro- and meso-level analyses developed across my later works on peace, conflict, resistance, and global transition. Whereas the 2025 publications (Steinmetz, 2025 a- d) about peace and resistance

[1] https://www.umcutrecht.nl/nieuws/jim-van-os-pleit-in-nature-voor-afscheid-van-dsm

examine the global order's structural deficiencies—ranging from (neo)colonial continuities and white superiority to systemic crises, authoritarianism, and the fragmentation of worldviews—the AlleKleur article reveals how these same forces materialise in **everyday life**, particularly within the experiences of migrant communities.

From Global Transition to Micro-Level Reality

In the peace series (Steinmetz, 2025a–d), global transition is presented as multidimensional and crisis-driven: ecological degradation, geopolitical instability, cultural dislocation, and epistemic conflict. The AlleKleur study demonstrates how these structural pressures translate into **psychological strain**, **institutional exclusion**, and **social marginalisation** for immigrants and refugees in the Netherlands. The following conclusions are drawn by Steinmetz et al. (2012):

- Migrants' elevated levels of anxiety and depressive symptoms parallel the broader crisis of meaning and identity."
- Their struggles in education, labour markets, and neighbourhood life mirror the systemic inequalities analysed in the critiques of Western institutional design.
- These barriers are indicative of the structural hierarchies that are often associated with neo-colonial power and the institution of white supremacy.

Through these micro-level experiences, Steinmetz (2012) offers a lived illustration of global forces that were identified at the macro level.

Peace as a Lived Experience: The Role of Cultural Competence

Steinmetz (2025 A-D) peace theory work highlights the tension between **Western individualism** and **non-Western relational worldviews**, especially Ubuntu. The AlleKleur approach embodies a tangible operationalisation of this non-Western logic in a Western context of the cities of Amsterdam, The Haque and Amersfoort.

- Therapy in clients' mother tongue is grounded in **relational understandings of emotion**, aligning with transcultural psychological insight.
- The integrated **Socially Embedded Method**—linking mental health to education, employment, and social networks—enacts peace as **holistic wellbeing**, not mere symptom reduction.
- AlleKleur practitioners serve as culturally anchored mediators, supporting clients' dignity and agency in a world that often invalidates both.

Through this, the 2012 article provides the micro-level methodology that the first authors works conceptualize as necessary for peacebuilding.

Conflict as Structural, Relational, Nature of Incidents and Contextual

The conflict formula -F(C | EHS-LM-BS-PFR) = VPB & NI- emphasizes context, relationships, and the nature of incidents (NI) (Steinmetz, 2025). The AlleKleur study exemplifies how:

- Conflicts are embedded in Education & Health Systems (EHS), Labour Markets (LM), Bureaucratic Structures (BS) and Peer and Family Relations (PFR)
- The notion of immigrant and refugee mental health cannot be considered in isolation from the social context, as is emphasised in formulaic discourse.
- Victim–perpetrator–bystander dynamics (VPB) appear in subtle forms: schools that fail to show belonging to children and their caregivers, municipalities that underfund mutual belonging, and healthcare institutions that impose monocultural norms.

This article thus provides empirical grounding for your theoretical insistence that conflict must be analysed within its sociocultural ecology.

Resistance, Agency, and Social Cohesion

The across one's lifelong narrative, resistance—moral, political, physical, organisational—is a recurring pattern. In the AlleKleur article, this ethos reappears:

- Migrants express strong aspirations for participation, volunteerism, and social mobility (p. 18), reflecting agency rather than passivity.
- AlleKleur challenges mainstream psychiatric norms, resisting systems that reproduce inequality.
- The organisation's work fosters **social cohesion**, a key component of peacebuilding in the later developed theoretical framework.

This demonstrates how micro-level acts of care and inclusion become forms of peace praxis, resisting larger systemic forces.

The Continuity of Social Exclusion as Violence

Steinmetz's broader works define systemic injustice as a form of structural violence. The 2012 article makes this visible:

- Migrants face invisible barriers that function as mechanisms of exclusion: language expectations, labour discrimination, limited access to networks.
- The study reveals how exclusion communicates a hierarchy of human worth, echoing the 2025 findings on Amsterdam's educational system (Crul et al. 2025)
- These patterns replicate colonial-era distinctions between "first-class" and "second-class" people—a theme central to the analysis of Western–non-Western tensions.

Thus, the AlleKleur data provide micro-evidence for your argument that peace is impossible without confronting the structural violence embedded in institutions.

Micro-Level Peace as Foundation for Global Peace

My 2025 works argue that macro-level peace requires micro-level transformation.

The AlleKleur model shows:

- Peace begins with cultural recognition, linguistic dignity, and social belonging.
- Health and wellbeing are inseparable from justice and inclusion.
- Successful peacebuilding requires bridging worldviews—not erasing identity, but integrating difference.

This article thus serves as an early, practical articulation of your later theoretical argument: peace is not only a geopolitical construct but a **daily practice**, enacted in therapeutic spaces, neighbourhoods, schools, and workplaces.

Conclusion

By connecting the 2012 AlleKleur findings to a broader scholarship, a clear continuity emerges: the micro-level struggles of migrants in Amsterdam illuminate the same structural, cultural, and political dynamics you later identify at the global scale. The article stands as a foundational empirical case demonstrating how conflict, exclusion, and inequality shape lived experience—and how culturally grounded, relational, and justice-oriented practices form the necessary conditions for authentic peace.

In this way, the AlleKleur study enriches the comprehensive peace framework by anchoring its theoretical claims in lived reality, offering a concrete model for how micro-level interventions can embody the larger project of building a peaceful world.

PSYCHIATRY AND NON-WESTERN BUREAUCRATIC

Psychiatry in non-Western contexts faces significant bureaucratic obstacles, including cultural stigma, a lack of government prioritization for mental health, and the clash between Western-based models and local cultural values.

These issues are compounded by systemic challenges such as corruption, limited healthcare infrastructure, a lack of trained personnel, and the tendency to rely on medication over other interventions. Bureaucracy is also a hurdle in terms of legal and policy frameworks, such as psychiatric advance directives (PADs) being misaligned with collective cultural norms and facing mistrust from communities with histories of exploitation.

Cultural and Societal Barriers

1. **Stigma**: Stigma is a major barrier, often leading to a reluctance to seek treatment. It is exacerbated by factors like the perceived incompatibility of Western diagnoses with local beliefs and values.
2. **Cultural values**: Collective and familial health decision-making norms are common in many non-Western cultures and can conflict with Western-based models that emphasize individual autonomy, as seen with the case of PADs.
3. **Alternative beliefs**: The preference for traditional healers and spiritual or religious approaches to mental health can be a significant factor, especially in regions like the Middle East and parts of Asia.

Systemic and Bureaucratic Obstacles

1. **Policy and funding**: Mental health often lacks sufficient government attention and funding, with resources sometimes diverted to other health issues or misused due to corruption.
2. **Infrastructure**: A historical reliance on large, centralized hospitals and an absence of mental health support in primary care create access barriers.
3. **Legal frameworks**: Bureaucratic and legal systems may not be culturally sensitive. For example, PADs, designed in a Western context, can clash with cultural values and be met with mistrust, particularly in communities with a history of punitive legal systems or colonialism.
4. **Training and resources**: There is often a lack of trained professionals and inadequate knowledge of mental health services among primary care providers. The overreliance on medication is sometimes a result of the limited development or availability of other psychosocial interventions.

Healthcare Provider and Patient Interactions

1. **Lack of cultural competency**: A mismatch between the clinician's and patient's cultural worldviews can lead to misdiagnosis and ineffective treatment. For instance, physical complaints may be dismissed as the patient's "underdeveloped" way of expressing distress, rather than as a culturally meaningful expression of suffering.
2. **Shared decision-making**: A lack of person-centred care and shared decision-making can lead to patient dissatisfaction, even if they formally report satisfaction with the treatment overall.
3. **Mistrust**: A deep-seated mistrust of psychiatric and legal systems, particularly among immigrant communities, acts as a significant barrier to engagement.

PSYCHIATRY AND WESTERN BUREAUCRATIC OBSTACLES

Bureaucratic obstacles in Western psychiatry include complex legal and paperwork requirements for patients, long wait times for appointments, and a lack of coordination between different sectors like general health and social services. Other barriers involve professional and ideological differences between clinicians, systemic issues such as inadequate funding, and the challenges of navigating administrative burdens that can disproportionately affect marginalized groups.

Challenges for Patients and their Families

1. **Complex paperwork and legal hurdles:** Patients, particularly those with low health literacy, struggle to understand treatment options and complete complex forms and legal documents like Psychiatric Advance Directives (PADs).

2. **Financial burdens:** The costs associated with legal consultation, notarization, and document storage for things like PADs are often not affordable for low-income individuals. Insurance coverage can also be incomplete or difficult to access.
3. **Long wait times:** Significant wait times for appointments with psychiatrists and psychologists are common, even in countries with good healthcare systems, which can delay or worsen treatment outcomes.
4. **Lack of support:** Patients report difficulty finding support to help them navigate the complex system, leading to feelings of being overwhelmed and unable to access care.

Systemic and Structural Challenges

1. **Lack of coordination:** There is often a lack of collaboration and communication between different sectors, such as between general practice and psychiatry, or between mental health and social services.
2. **Organizational and leadership gaps:** Some studies point to a lack of leadership and organizational support to establish effective, trans-sectoral collaboration and to remove barriers related to legislation and technology.
3. **Resource limitations:** Issues include a lack of adequate facilities, an over-investment in expensive technology instead of direct care, and insufficient resources for mental health support workforces.
4. **Routinization and rationing:** Healthcare workers may use standardized approaches ("routinising") and ration access to services to cope with high workloads, which can compromise the quality of care.
5. **Systemic bias:** Bureaucratic burdens can disproportionately affect marginalized groups, creating instances of "bureaucratic injustice".

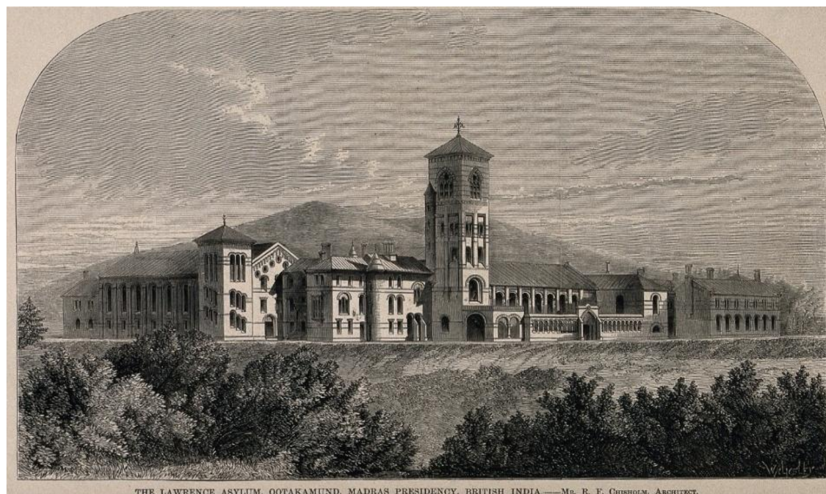
Professional and Ideological Hurdles

1. **Professional silos:** Differences in professional ideologies and treatment principles between sectors can hamper dialogue and collaboration.
2. **Lack of training and awareness:** Providers may lack sufficient training in mental health issues, including culturally specific needs, and adequate screening tools.
3. **Time constraints:** Systemic time constraints can prevent clinicians from performing thorough assessments, especially sociocultural ones.

INDIAN EXAMPLES OF BUREAUCRACY IN PSYCHIATRY AND PSYCHOLOGY

Below are concrete, institutional examples of how psychiatry and psychology in India have been organized bureaucratically — through state policy, legislation, hospitals, regulatory councils, and national programs. These are modern, documentable structures rather than only philosophical traditions (Waltraud, 1991; 2013 and Mills, 2000).

Colonial Institutional Psychiatry (19th–early 20th century) Lunatic Asylums → Mental Hospitals



THE LAWRENCE ASYLUM, OOTAKAMUND, MADRAS PRESIDENCY, BRITISH INDIA.—MR. R. F. CHISHOLM, ARCHITECT.

During British rule, psychiatry in India was formalized through custodial institutions.

The institutionalisation of psychiatry in colonial India illustrates the early formation of a medico-legal bureaucratic apparatus that combined administrative rationality with emerging psychiatric knowledge. Key institutions such as the Central Institute of Psychiatry (established in 1918 as the European Mental Hospital), Yerawada Mental Hospital in Pune[2] (founded in 1864), and the Madras Lunatic Asylum (established in 1794) exemplify the

[2] https://www.facebook.com/ZeeZest/posts/yerwada-mental-hospital-is-one-of-punes-most-well-known-hospitals-but-its-dark-h/1348924903257949/

geographical spread and administrative consolidation of psychiatric care under colonial governance.

This system was formalised through successive legislative frameworks, culminating in the Indian Lunacy Act of 1912, which standardised procedures for admission, treatment, and discharge. Earlier legislative efforts, including the Lunacy Acts of 1858, had already laid the groundwork by regulating the establishment of asylums and codifying admission processes. As discussed in historical analyses of colonial administration (e.g., Bhattacharyya, 1996; Ernst, 1991), these developments reflected a broader bureaucratic logic characterised by a state-run confinement model, a superintendent-led institutional hierarchy, and the central role of magistrates in authorising admissions.

Within this framework, psychiatry became embedded in colonial administrative structures as a medico-legal system. Patients were subject to legal procedures for confinement, asylums functioned as state-controlled institutions, and administrative authority gradually shifted from police oversight to medically trained civil surgeons and psychiatrists. This transition marks a significant moment in the professionalisation of psychiatry, while simultaneously underscoring its entanglement with mechanisms of governance, control, and social regulation.

Post-Independence Institutional Psychiatry National Mental Health Infrastructure

After 1947 India indigenized and expanded psychiatric governance.

The National Institute of Mental Health and Neurosciences is a flagship institution in India’s mental health system, operating under the framework of the NIMHANS Act, 2012 (Government of India), and discussed in works such as Jain (2013) and Venkoba (1980). It is an autonomous institute under the Ministry of Health and Family Welfare and serves as a national centre for training, research, and policy advisory.

NIMHANS plays a central role in producing mental health professionals, including psychiatrists, clinical psychologists, and psychiatric social workers. Its bureaucratic structure is characterised by central government funding, leadership through a director appointed by the Ministry of Health, and the integration of academic, clinical, and research functions within a single institutional framework. In addition, it operates in compliance with national regulatory acts governing mental health and professional standards.

Through these functions, NIMHANS acts not only as a major hospital and training institution but also as a key policy node within India’s psychiatric bureaucracy, linking service delivery, knowledge production, and state governance.

National Mental Health Programme (NMHP) Public Mental Health Administration

The National Mental Health Programme (NMHP) was launched in 1982 as a key policy initiative to expand access to mental health services in India (Murthy, 2011; Agarwal, 2004). It is administered by the Ministry of Health and Family Welfare in collaboration with State Health Departments, reflecting a shared governance structure between central and state authorities.

The programme is organised around the District Mental Health Programme (DMHP) model, which aims to integrate mental health services into primary health centres and local healthcare systems. Its implementation has historically been supported through budget allocations within Five-Year Plans and relies on coordination between central and state levels of government.

Overall, the NMHP represents a decentralised bureaucratic mechanism designed to deliver psychiatric services at the district level, bringing mental healthcare closer to communities and embedding it within general public health infrastructure.

Mental Healthcare Act (2017) (Act No. 10 of 2017), Government of India

Legal–bureaucratic reform in Indian mental health governance, particularly as analysed by Richard M Duffy et al. (2019) and Vikram Patel et al. (2012), marks a significant transition towards a rights-based framework. Central to this reform is the establishment of regulatory bodies, notably the Central Mental Health Authority (CMHA) and the State Mental Health Authorities (SMHAs), which are tasked with overseeing the implementation, standardisation, and monitoring of mental health services across jurisdictions.

The reform introduces several concrete administrative provisions that institutionalise accountability and patient protection. These include the mandatory registration of all mental health establishments, the formalisation of a patient rights charter, and the creation of Mental Health Review Boards functioning as quasi-judicial bodies to adjudicate disputes and safeguard individual rights. Additionally, the introduction of advance directives for psychiatric treatment enables individuals to articulate their treatment preferences in anticipation of periods of impaired decision-making capacity.

Taken together, these measures reflect a paradigmatic shift from a predominantly custodial model of psychiatric care—historically embedded in colonial and postcolonial administrative structures—towards a governance framework grounded in human rights, autonomy, and legal oversight. This transformation signals not only a reconfiguration of

institutional practices but also a broader normative reorientation in the relationship between the state, mental health systems, and service users.

Regulation of Clinical Psychology & Allied Professions Rehabilitation Council of India (RCI) [amended 2000]

REHABILITATION COUNCIL OF INDIA

Govt. of India

e-REGISTRATION CERTIFICATE

REHABILITATION PROFESSIONAL

CRR NO. [illegible]

The regulation of psychological practice in India is grounded in the Rehabilitation Council of India Act, 1992 (amended in 2000), which established a statutory body under the Ministry of Social Justice and Empowerment (Khandelwal et al., 2010). The Rehabilitation Council of India functions as the central authority responsible for overseeing professional standards in the field of rehabilitation and clinical psychology.

Its bureaucratic role is defined by several core regulatory functions. These include licensing clinical psychologists, approving and monitoring training programmes, maintaining a centralised professional registry, and standardising qualifications across the country. Through these mechanisms, the Council ensures uniformity, accountability, and professional competence within the field. Overall, this framework represents a centralised regulatory bureaucracy governing psychological practice, reflecting a structured approach to professional oversight and the institutionalisation of standards at the national level.

Indian Psychiatric Society (Professional Governance) Indian Psychiatric Society (Trivedi et al. 2001)

The Indian Psychiatric Society plays an important role in the governance of psychiatric practice in India. Although it is not a state body, it exerts significant influence over the professional field through a range of institutional and knowledge-based functions (Trivedi et al., 2001).

Its activities include the development of national treatment guidelines, the organisation of continuing medical education programmes, and active engagement in policy advocacy. In addition, the Society serves as an important interface between psychiatric professionals and government ministries, contributing expert knowledge to policy discussions and reform processes. In this sense, the Indian Psychiatric Society can be understood as a semi-formal epistemic bureaucracy within the profession. It operates through the production, standardisation, and dissemination of knowledge, thereby shaping clinical practice and influencing the broader governance of mental health in India.

AYUSH & Integrative Psychological Systems

Ministry of AYUSH (Government of India). Annual Reports (2014 ….)

Bureaucratic developments in Indian mental health governance reflect the continued relevance of plural medical systems (Sujatha, 2007; Brass, 1972). State institutions support and regulate traditional approaches alongside biomedical psychiatry, for example by funding Ayurvedic psychiatric departments, regulating certification processes for Yoga-based therapies, and facilitating the integration of traditional psychological systems into public hospital settings.

These administrative practices demonstrate how governance structures extend beyond a purely biomedical model. Instead, they institutionalise multiple knowledge traditions within the same regulatory framework, allowing for parallel forms of training, treatment, and professional recognition.

As a result, a dual-track bureaucratic system has emerged. On the one hand, biomedical psychiatry operates through formal medical institutions, legal frameworks, and professional licensing. On the other hand, traditional psychological medicine—rooted in systems such as Ayurveda and Yoga—is supported and regulated through state-backed

programmes and certification mechanisms. This coexistence reflects a hybrid model of governance in which diverse epistemologies are incorporated into public mental health infrastructure.

Forensic Psychiatry & Legal Interface (Sarin et al. 2013; Pinto 2014; Mills et al. 2004)

Mental health bureaucracy in India extends beyond clinical institutions and is closely interconnected with a range of legal and administrative bodies. These include district courts, prison psychiatric units, disability certification boards, and directives issued by the Supreme Court of India on institutional reform. Together, these actors form a broader governance network in which mental health is regulated through both medical and legal frameworks.

Within this system, psychiatric assessment frequently takes place through legally mandated boards and procedures. Such assessments are often required for judicial decisions, disability certification, or custodial evaluations, embedding psychiatric expertise within formal legal processes.

This configuration reflects a highly formalised medico-legal structure, in which mental health practice is shaped not only by clinical considerations but also by legal mandates, administrative oversight, and judicial intervention.

Structural Characteristics of Indian Psychiatric Bureaucracy

Feature	Indian Model
Central–State split	Strong
Legal framework	Rights-based (post-2017)
Professional licensing	Central registry (RCI)
Public health integration	District-level delivery
Traditional systems	Parallel bureaucratic inclusion
Colonial legacy	Institutional origins

INDIAN AND CHINES WORLDVIEWS AND PSYCHIATRY

Theoretical Framework: Worldviews, Bureaucracy, and Psychiatry

Psychiatric systems are not merely medical institutions in the conventional sense; rather, they are embedded within broader cultural worldviews, political systems, and administrative traditions. The organisation of psychiatry, as reflected in its diagnostic systems, institutional structures, professional hierarchies, and patient–doctor relationships, reflects underlying civilizational assumptions concerning the self, society, authority, and knowledge. From a sociological perspective, psychiatry can therefore be understood as both a medical and a bureaucratic system shaped by cultural models of personhood and social order.

This theoretical perspective draws on three major bodies of thought: the sociology of bureaucracy developed by Max Weber, the concept of medical governance and biopolitics developed by Michel Foucault, and the sociology of professions as theorised by Andrew Abbott. The integration of these frameworks allows for an analysis of psychiatry as an

institutional system that operates through administrative structures, legal frameworks, and professional regulation (Weber, 1922; Foucault, 1961; Abbott, 1988).

Bureaucracy and Psychiatry

In sociology, bureaucracy is defined by Weber as an organisational system characterised by hierarchy, codified rules, specialised training, and administrative oversight (Weber, 1922). Modern psychiatry closely follows this model: psychiatrists are licensed professionals, hospitals are hierarchical organisations, diagnoses are standardised, and treatment is regulated by legal and insurance systems. Psychiatry therefore functions not only as a medical discipline but also as a bureaucratic institution that classifies, manages, and regulates human behaviour.

Foucault argued that the historical development of psychiatry has been intertwined with broader systems of social control, particularly through institutions such as asylums, prisons, and hospitals (Foucault, 1961). He described this process as biopolitics: the governance of populations through medical and administrative systems (Foucault, 1976). From this perspective, psychiatric diagnosis is not purely a clinical act but also an administrative classification with consequences for legal responsibility, access to treatment, insurance, and social status. Psychiatry can therefore be understood as part of what Nikolas Rose later described as the “governance of the soul,” in which psychological knowledge becomes a tool of modern administration (Rose, 1999).

This theoretical approach is particularly relevant in colonial and postcolonial contexts, such as India, where psychiatric institutions developed within colonial administrative systems (Ernst, 2013; Mills, 2000).

Indian Worldview and Psychiatry

The Indian worldview has traditionally understood mental suffering not only as an individual medical problem but also as a moral, social, and spiritual imbalance. Concepts such as dharma (social and cosmic order), karma (moral causation), and relational duty imply that the individual cannot be separated from family, community, and cosmic order (Radhakrishnan, 1923; Dumont, 1966). The person is therefore understood as fundamentally relational rather than purely individual.

As a result, mental health in India has historically been treated through plural systems, including family care, religious institutions, Ayurvedic medicine, yoga, and later biomedical psychiatry (Kakar, 1982; Kleinman, 1980). This pluralistic worldview helps explain why modern Indian psychiatry developed as a dual system consisting of:

1. A Western-style biomedical psychiatric system (hospitals, diagnoses, medication)
2. Traditional and community-based systems (family care, religious healing, Ayurveda, yoga)

The coexistence of these systems required administrative coordination, which contributed to the development of psychiatric bureaucracy in the form of national programs, licensing bodies, and mental health legislation. Psychiatry in India therefore became a

hybrid system combining colonial institutional structures with indigenous medical and social traditions (Ernst, 2013).

Scholars such as Ashis Nandy have argued that colonialism introduced Western psychiatric categories that did not always align with Indian cultural understandings of the self, leading to tensions between bureaucratic diagnosis and lived experience (Nandy, 1983). Similarly, Sudhir Kakar demonstrated that Indian concepts of the self are deeply embedded in family and religious structures, which affects how mental illness is experienced and treated (Kakar, 1982).

Chinese Worldview and Psychiatry

The Chinese worldview, influenced by Confucianism and Daoism, emphasises social harmony, relational roles, and social stability rather than individual autonomy (Fei, 1992; Bell, 2015). Within Confucian philosophy, the person is defined by their role within the family and society, and social harmony is considered a primary social goal.

Historically, Chinese governance developed through a highly organised bureaucratic state influenced by Confucian administrative philosophy. This tradition contributed to a state-centred model of healthcare in which mental health services are closely integrated with state administration and community management structures (Phillips, 2004).

Anthropologist and psychiatrist Arthur Kleinman showed that in Chinese society mental illness has often been understood as a disruption of social harmony rather than purely an internal disorder (Kleinman, 1986). As a result, psychiatry in China developed as a state-administered system closely connected to hospitals, work units, and community administrative structures. The focus is often on restoring social functioning and stability rather than only treating individual symptoms.

Thus, while Western psychiatry emphasises individual diagnosis and treatment, the Chinese system has historically emphasised social functioning, family responsibility, and state coordination, reflecting the broader bureaucratic and relational structure of Chinese society (Fei, 1992; Kleinman, 1986).

Comparative Theoretical Insight

These different worldviews produce different psychiatric systems because they are based on different assumptions about the person, the family, and the state. Cross-cultural psychologists such as Richard Nisbett and Geert Hofstede have demonstrated that Western societies tend to emphasise individualism, while Asian societies tend to emphasise relational and collective social structures (Nisbett, 2003; Hofstede, 2001). These cultural differences influence how mental illness is understood, diagnosed, and treated.

From a sociological perspective, psychiatry can therefore be understood as a cultural–bureaucratic system, not just a medical one. Diagnostic systems, hospital structures, and mental health laws reflect deeper assumptions about individual versus collective identity, the role of the state, the role of the family, the nature of suffering, and the authority of experts.

Implications for Migrant and Intercultural Psychiatry

When people migrate, they move from one psychiatric–bureaucratic system to another. Migrants from India, China, the Middle East, or Africa often encounter Western psychiatric systems that are highly bureaucratic, individualistic, and diagnosis-oriented. This can lead to mistrust, misdiagnosis, dropout from treatment, communication problems, and different expectations of care (Bhugra, 2001; Fernando, 2010).

Intercultural mental health models attempt to bridge these different worldviews by integrating social support, cultural understanding, language, and community participation into psychiatric treatment. Cultural psychiatry research has shown that mental health outcomes improve when treatment systems take cultural models of the self and family into account (Kirmayer, 2001; Kleinman, 1980).

Theoretical Conclusion

From a theoretical perspective, psychiatry operates at the intersection of medicine, bureaucracy, law, culture, social structure, and political systems. Mental health systems are therefore not culturally neutral; they are institutional expressions of civilizational worldviews (Weber, 1922; Foucault, 1961; Rose, 1999).

This theoretical framework helps explain why bureaucratic barriers in mental health care disproportionately affect migrants and non-Western populations, and why culturally embedded and socially oriented mental health models are often more effective in intercultural contexts.

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