Gilbert, J. (1994) A Gambian Experience. **Changes, 12(3**), 165-169.

A Gambian Experience

It is almost three years since I returned to England from The Gambia. The pressures of a psychologist's job in the NHS, and the presence of young children have made it difficult to find time for writing until now. Most of what follows was actually written one year after my arrival, when I felt it was essential to try and capture the "essences" (as much as one can in words) of both my personal and professional experience there. In reality of course those two aspects of me can never be separated. Now that I come to read what I wrote then, I notice that much of it is in the present tense. The grammar may seem strange but I have decided to leave it that way.

I have to confess to a life long love affair with Africa and its peoples (I lived there earlier in my life). I am also a clinical psychologist. Attempting to integrate those different parts of me is a continuing struggle, although my time in The Gambia helped me to understand, for the first time, that some kind of integration might be possible. In writing this I should like to describe some of my experiences then and my subsequent attempts to make sense of that experience later.

As it was then

I came as a "spouse" as one is referred to in official documents, so no job to come to, and certainly no advertisements for clinical psychologists. In a country where almost no one has ever heard of clinical psychology, could it have any relevance?

My previous work was in a community team in Derbyshire, so some degree of culture shock to poverty, deprivation and climate were to be expected. (Even though I had been in Africa before, one "forgets" the reality of poverty.) I also, surprisingly soon, experienced great grief at my loss of identity and loss of professional network. However, knowing that I could not contribute anything at all until I had acquired some "culturally appropriate" understanding, I arranged to attend the country's only psychiatric unit to simply observe. It was agreed that I could then make my own suggestions as to what contribution I might make.

On a practical level, compared with the West, conditions at the psychiatric unit are appalling, with continual water, electricity and food problems. (How I wish NHS staff could see this.) It is an old prison with its stone cells crowded with approximately 70 inpatients. To my delight I found two British trained Gambian psychiatric nurses who had both worked with psychologists before, and who made me most welcome. They are the only qualified staff in The Gambia. There is no psychiatrist, simply one medical officer on contract with DFID, who "covers" psychiatry in one two hour ward round per week.

Sitting in on these ward rounds was an education in itself, and enabled me to begin to gain an understanding of mental illness and its cultural manifestations here. Most patients are "diagnosed" (I put that in quotes because the medical officer was less than competent) as suffering from schizophrenia, drug induced psychosis or brief reactive psychosis. They were then prescribed drug treatment from the limited range available. Listening to the content of delusional systems, thought disorder, provided an insight into cultural beliefs where madness is believed to be caused by witches, the devil or evil spells. In addition, relatives provided details of family relationships where households of four wives are quite usual and arranged marriages normal practice. I learned a great deal in those first few months, and of course an added bonus from any in depth exposure to another culture is the opportunity it gives for sober reflection on one's own: my own predominant thoughts being on the spiritual poverty of our Western lifestyle and the inherent meaningless of our consumer driven economic system.

Although I was fascinated by the differences, could I contribute anything? Was my background totally irrelevant in a situation where the necessities of food, water and shelter are most people's greatest concern? Although most people spoke English, it was clear that psychotherapy was not possible.

The Gambian nurses were convinced that my most valuable contribution could be teaching. It transpired that the Nursing School was shortly to introduce a 12 week psychiatric module into its curriculum for the first time and before I quite knew what had happened, I was in charge of it, all at two weeks' notice. (It seems that's usually the way things happen in Africa, either unbearably slowly, not at all, or incredibly suddenly on the spur of the moment.)

My previous experience of teaching was not great, and I had enormous doubts as to my suitability as a tutor in mental health to a class of 24 Gambians, whose background and culture was so different from mine. Not one to refuse a challenge, I decided to simply take it on. There were some practical problems such as no textbooks, no paper and no photocopying facilities – minor difficulties.

I worked very closely with the Gambian class tutor, and together we prepared the timetable for the month's teaching and the eight weeks of practical experience. I could write a book on my teaching experience alone. It was also the hottest time of the year, the wet season. Do you think you could teach in 35 degrees with 90% humidity and no fan or air conditioning? I thought I could not either but …..

I learned a huge amount from my students. It seemed to be so much more than they learned from me, although feedback from them was overwhelmingly positive, particularly on my "unorthodox" (by Gambian standards) teaching methods, i.e. asking them to work in groups and produce their own ideas. I had been assured by someone who had lived there for 20 years that such methods would fail absolutely as all children in school here are in classes of about 60, simply sitting in rows, absorbing information from the teacher and

reproducing the information later. After the students' initial shock (which was considerable) they responded with great enthusiasm.

The psychiatric unit is too small to accommodate 24 students simultaneously, so other practical projects had to be devised. I had realised very soon after my arrival that the majority of people consult a marabout (traditional healer) for any physical or mental problem before turning to Western medicine, so it seemed reasonable to find out more. I suggested that each group of eight students interview four marabouts. The students were very excited about this project and the results were fascinating. As well as learning about their treatments of herbs and recitations from the Qur'an, it transpired that their diagnostic system was quite specific, and bore a marked resemblance to the Western model. Although mental problems were classified as being caused by witches, spells and so on, when types of symptoms were considered, the marabouts made clear distinctions between what we might call psychoses, neuroses, mental handicap and drug induced states.

For the other practical project, I asked the students to choose some are of mental health education. They all chose drug abuse, a reflection of the seriousness of the drug problem here. They prepared and gave talks and presentations to members of a youth group and selected classes at secondary school.

In close collaboration with the two psychiatric nurses I "supervised" the students during their time at the psychiatric unit. There were always practical difficulties, e.g. the water was off, the rice had not been delivered, but most of the objectives we had agreed on were achieved. As there is no community based psychiatric service, once someone is discharged from the unit they simply "disappear". My suggestion that students should actually follow up some discharged patients (a previously unheard of occurrence) was a highlight of the practical, both of myself and the students. Inspite of the difficulties of finding where anyone lived when street names and numbers are extremely rare, it was an opportunity for me to go with the students into people's homes, at a level of poverty that I had never experienced at such close quarters. There is no doubt that for me, having had the privilege of being welcomed into such poor abodes, I emerged humbled and yet again appalled at the depersonalisation inherent in so many aspects of my own lifestyle and culture. It is difficult to describe the experience adequately.

Those 12 weeks were very intensive so I came down with a "bump". What next? (I had no "proper" job.) The Department of Health were setting up a task force to consider mental health issues and I was invited to join. So far it has met at irregular intervals over the past eight months. It is an incredibly frustrating experience as there are always "problems" that prevent anything from actually happening. It is also very distressing not to have any power to effect any changes because I have no official position. It is, however, excellent experience for me in developing patience and a much better understanding of the political complexities here (if I can survive it).

Another part of my "independent consultancy" is a short term contract with Peace Corps (the American volunteer agency). My brief is to interview their present volunteers and staff, identify major causes of stress and devise some relevant input to their initial training programme to increase volunteers' coping skills and, theoretically, help prevent drop out (their drop out rate is consistently higher than that of VSO). A tall order, but the volunteers make a great contribution here so it seems worthwhile.

All in all it is a strange existence. I miss professional support very much indeed, but I am certainly having some very taxing training in psychological survival.

Reflections

Personal circumstances dictated an earlier than expected return to the UK. The nine week overland drive through West Africa and across the Sahara helped dull the pain of leaving Africa (again), as there was so much planning and preparation to be done. However, inescapably, I was plunged into a British January (so dark), coming to grips with a full time NHS job, struggling to understand all the changes that seemed to have occurred in my absence, and once again suffering the acute shock of returning to my own affluent Western culture.

I was, however, determined to find out more about psychology in Africa and "make some sense" of my time there. My practical experience in The Gambia had shown me for the first time that it might be possible to integrate these disparate parts of me, so with a very helpful, but somewhat bemused librarian, I began an erratic literature search.

There seem to be so many articles debating whether a Western based psychology could have any relevance at all. It was difficult to find any articles on what anyone was actually doing. I was impressed by Sloan (1990) who argues strongly that a committed psychology should concern itself with what he calls "defensive dehumanisation", the phenomenon in our own culture which allows the developed world to proceed on the path of ever increasing affluence and consumption of resources, inspite of more media coverage than ever of the realities of the other two thirds of the world.

Although there is a great need for psychology to consider the attitudes and behaviour of the West, I feel psychology does also have a contribution to make in developing countries. Although the nature of that contribution could vary enormously, an essential component seems to be, must be, **not** the wholesale export of another Western system of thought (that is being done, often with devastating results, all too powerfully through the power of Western media and multi-national business), but a joining together, actively seeking parallels, and searching for common ways of construing. So often traditional societies simply abandon their wisdom in the face of the ongoing onslaught from the West, somehow being made to feel that their own ways are inadequate and inferior. Although the consequences are often tragic, the developing world cannot be protected from the insidious spread of Western

value systems. If psychology is to be involved, such active seeking of commonalities could contribute both to greater cross cultural understanding and also to traditional approaches being more actively valued by the people themselves.

In reviewing my own experience now, I realise that what I had done instinctively was to constantly look for connections. I discovered that my most valuable psychological skills were those of facilitating, joining, and seeking out similarities and parallels, which were not immediately apparent. I did not see myself as an "expert" conveying "superior knowledge", even though that is often how Westerners behave. Rather it seemed essential that the students and I were engaged on a **joint** process, attempting to integrate what appear, on the surface to be radically different paradigms.

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Reference

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