

Gilbert, J. (2000) Crossing the Cultural Divide? **The Health Exchange**, April, 15-16.

***“The February 2000 issue of The Health Exchange examined the mental health care debate. Jane Gilbert, a Consultant Clinical Psychologist, responds, focussing on “the complex cultural factors which make doing work which does not harm more difficult in this area than in other kinds of international aid work”.***

## **Crossing the Cultural Divide?**

While agreeing with much of Kaz de Jong and Sue Prosser’s overview, I felt that some crucial points were not sufficiently clear. Every culture has a particular “worldview” – the set of assumptions by which people make sense of the world and their experience of it. In the North, these cultural assumptions are predominantly based on science and rational thought and have led to the high emphasis placed on objective understanding and labelling of phenomena. This focus on rational objective criteria has led, *inter alia*, to the development of the “medical model”: symptoms can be classified into particular diagnostic entities, which can be identified and labelled, and then appropriate treatment, most often in the form of medication, can be applied.

This model takes very little account of social, spiritual or individual psychological factors; it also assumes that, if sets of symptoms appear to be similar, then similar treatments can be applied. This model underpins psychiatry in the North, and informs the kind of language used to describe mental health problems, e.g. depressive illness, schizophrenic illness, anxiety disorders. This scientific model has been the basis of much cross cultural research into mental illness, research which has predominantly been concerned with examining symptoms in different cultures and attempting to fit them into diagnostic systems.

There are at least two profound difficulties with this approach. First, even in the UK, there is continuing and often vociferous disagreement about the causation and treatment of mental illness/mental health problems. The medicalised and symptom based language used by some professionals to describe the personal experience of mental distress is not necessarily accepted by other mental health workers or clients. To many practitioners, including myself, the notion that there are “valid instruments to both measure the levels of trauma and to quantify treatment effects” is controversial, and it is questionable whether any such instruments can accurately reflect the personal experience of distress, even in our own culture. Those who work within mental health services in the UK National Health Service (NHS) will know that these discussions/disagreements take place every day. Given such fundamental disagreements in our own culture, how can we set up “criteria” for help in cultures whose underlying assumptions, in terms of making sense of the world, are very different from our own?

Secondly, explanations for mental distress have to “make sense” to individuals and their families within a particular cultural context. Thus, even if “symptoms” appear the same in different cultures, how those symptoms are experienced by an individual and what that individual considers an appropriate label for his/her confusing and distressing feelings, and what explanations are considered culturally acceptable in a particular society is necessarily going to be very different. In many cultures, explanations for mental distress always have a strong spiritual component; any culturally credible method of cure would have to address this dimension explicitly. Thus, in many cultures a traditional healer, prescribing traditional remedies and rituals, is most often the first treatment of choice. De Jong and Prosser mention “culture bound” syndromes but, I felt, gave insufficient explanation of the term, and did not outline specifically how knowledge and understanding of such syndromes reveals so clearly the extreme care and caution that has to be taken in any mental health programme. Culture bound syndromes and symptoms refer to manifestations of mental distress which only appear in a particular culture, and have no direct equivalent in others. Also descriptions of some mental states cannot be translated, because there are no equivalent words. Difficulties in translation work both ways – common English words such as “stress” and “anxiety” often have no equivalent.

De Jong and Prosser’s use of terms such as “what are the minimal criteria” and “treatment methods” would be alien concepts in many cultures. Derek Summerfield and others have been vocal in their criticism of the use and relevance of checklists of symptoms for PTSD. If a person’s cultural world is based on the power of spiritual forces, ancestors, and the effectiveness of bewitchment, then that is where listening and respectful understanding must begin.

### **Mental illness/mental distress**

The overview did not make a sufficient distinction between mental illness, such as schizophrenia, and mental distress or psychological problems, which can be seen as normal responses to abnormal life events. Emotional distress of some kind is an unavoidable part of life’s sufferings and, through childhood and life experience, each person develops resistance and resilience. This varies between individuals. It is crucial that, if help is to be given, there is a very clear understanding beforehand of normal emotional strategies within a particular culture. Talking about one’s feelings to someone, whether it be friend or professional, is considered a “normal” reaction to distress whereas, in a different culture, that same strategy could be considered abnormal. It is also of paramount importance to be able to establish when normal, cultural coping mechanisms have been insufficient or have broken down so appropriate help can be given.

Having spent time with traditional healers specialising in mental health problems, I have seen those with psychoses tied up in chains for their own safety and the safety of the community because they could not be treated by traditional means. (Practices of containment previously used in our own culture before the development of anti-psychotic medication). Discussions

with healers revealed that all kinds of “ordinary” psychological problems were being helped by traditional methods. In terms of “The Health Exchange” coverage, I felt it was potentially confusing to discuss the effects of war and violence in the same breath as mental health and mental illness generally, without clearer distinctions being made.

### **Training curricula**

My contact with psychiatric nurse training in The Gambia, Malawi and Uganda revealed a UK psychiatric curriculum, even though 90% of the those with mental health problems would visit a traditional healer first, and understand their distress with a strong spiritual component. I was asked to teach a UK curriculum in The Gambia, and my struggles then to help students research their own culture, to visit traditional healers, and our completely shared desire to discover what parallels and similarities there were, showed me that, with great care and due reference to local language, it is possible to find syntheses between cultures.

As is the case in other areas of international aid, as soon as a Northern curriculum takes precedence over facilitating an understanding of local knowledge and experience, a subtle process of cultural imperialism takes place yet again. My own contact with nurses indicated that, very often, the imported “worldview” from the North is seen as “better”. Training of professional staff then subtly undermines and implicitly devalues traditional cultural beliefs. When those same professionals begin to work in their own country they do not have the local knowledge and understanding of traditional treatments, and, in effect speak a different “language”.

### **Take time and care**

De Jong and Prosser’s article states that “careful listening” is essential, but to ensure that any help given in mental health programmes is valid and not harmful to an individual’s own culturally appropriate coping mechanisms, traditional language and cultural beliefs must be understood first. This process takes time and great care, and involves the validation of individuals’ perceptions and understanding of their own psychological difficulties within the particular cultural social systems and networks in which mental health problems are defined, and the healers who provide culturally appropriate care. It is necessary for those professionals who are proposing to help in this field to openly and clearly address and articulate their own assumptions and prejudices, and acknowledge the limitations and confusion in our own culture. This must be an integral part of the process if relevant and effective help for the misery and unhappiness caused by all kinds of mental distress is to be given.

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