

RESPONDING TO MENTAL DISTRESS: CULTURAL IMPERIALISM OR THE STRUGGLE FOR SYNTHESIS?

Abstract

This paper questions the appropriateness of some of the “help” that has already been given in mental health in the South, particularly Africa, and examines some of the complex ideological issues underlying different cultural understandings of the aetiology and treatment of mental illness. Some personal experiences, illustrating examples of the imposition of culturally inappropriate ideology in the teaching of psychiatry are described. In conclusion, some principles of good practice are suggested which could form the basis of a synthesis between cultures, and maximise the possibility of aid from the North in the area of mental distress being more culturally relevant.

Mental illness and ideology

Mental disorder is found and recognised in all societies. However, how it is shown in individual behaviour, what people think causes the disorder, and what treatment is considered appropriate, varies tremendously among cultures. Although some types of psychotic illness appear to have similar symptoms across cultures, other types of problems have been found to be “culture bound”. In other words they are found only in one particular culture and not in any other (Kirmayer, 1989; Munford, 1996; Patel et al 1995; Witzum et al. 1996).

However, even when symptoms **appear** similar, **how** they are understood is totally dependent on the cultural context. In any culture, the predominant approach to mental illness is inseparable from the particular “world view” held by that society, the ways that are considered acceptable for making sense of human experience. Ideological issues cannot be discussed in depth here, but they are of paramount importance, as it is a particular world view that is being exported North to South, not value free “help” (Gronemeyer, 1992). Although there may be dissent among professionals in the North in the mental health field, the predominant model in psychiatry in the North is that used in medicine: the “medical model”. This has, as its basis, the classification of symptoms into particular diagnostic entities, the identification and labelling of those conditions, and the application of treatment, most often in the form of medication. The medical model is directly rooted in the North’s emphasis on **science** as the preferred mode for understanding the world. Stemming from this medical model and scientific framework, a great deal of cross cultural research in mental illness has been devoted to applying the West’s classification system to other cultures in an attempt to validate a “universal” diagnostic system for mental disorder (Ben Tovim, 1985; Kirmayer, 1991;

Littlewood, 1992; Sartorius et al, 1993; Weis et al, 1995). In researching the literature, it is surprising that this endeavour has been so persistent, in spite of increasing awareness of culture bound syndromes and the reservations of researchers who have attempted to use standardised classification systems (Edgerton & Cohen, 1994; Littlewood, 1992; Susser et al, 1995; Weis et al, 1995).

Approaches to mental distress: what can the North offer?

Can approaches developed in the North offer anything useful and non damaging to very different cultures? In medicine there is at least a broad consensus about the causation of physical disease and how it can be treated. Though there is debate, it is generally agreed that people's bodies contain the same parts and work in the same ways! However, there is much less consensus in the North about the treatment of mental distress. Many of its basic tenets, i.e. the biological basis of schizophrenic conditions are completely rejected by other professional workers in the field (Marshall, 1999; Boyle, 1996). Those who are being treated and who are in distress often remain confused as to how to understand what is the matter, given the lack of a unitary model among professionals. These disagreements in the North continue unabated and show little sign of resolution.

Given the fragmented and disjointed nature of psychiatry and mental health services in the North, what seems to have been exported to "less developed" countries so far? What might the contribution of psychiatry be now that mental health is very much on the international aid agenda? The literature reveals many studies on the incidence of mental illness in other cultures, and on validating measuring tools, but there appears to be very little about specific ways of working and what is actually happening. I will review some of my own experience, while recognising that the situation in other countries may be very different, and that changes may have occurred.

Personal observations

The primacy of the Primary Health Care Team (PHCT) as a model of care in "less developed" countries is now well established. It is generally recognised that providing health services in the same way as the North is not either practically or financially possible. Thus it falls to nursing staff to work at village level – dispensing medicines, training village health workers, conducting health education programmes, and operating as the essential foundation for all services, including mental health. Thus it seems of paramount importance to consider their role and to review what kind of training they are receiving.

The Gambia

While I lived in The Gambia I was asked to teach the "psychiatry module" at the School of Nursing in Banjul. At that time there was no psychiatrist in the country and the input to the psychiatric unit was given by a general physician with no specific training in psychiatry. The curriculum was taken directly from

the UK and that was what I was expected to teach. It seemed amazingly inappropriate in Banjul and I was already aware that the majority of people would always consult a marabout (traditional healer) first for any mental problem. It seemed essential that I modify the curriculum to maximise the links between traditional approaches to mental illness and models from my own culture, as well as assisting the students to research the belief systems of their own culture (Gilbert, 1994).

Malawi

Perhaps the imposition of an inappropriate curriculum was only limited to The Gambia? In 1994 I visited Malawi. Again, at that time, there was no psychiatrist in post in the country. The psychiatry module at the Medical School contained no reference to traditional beliefs and the staff at the single mental hospital (being most humanely run by nursing staff in very difficult circumstances) focussed almost solely on the administration of a limited amount of drugs.

In 1996 I was contacted for a general discussion by a psychiatrist in Bristol, UK who was volunteering to teach the “psychiatry module” at the Medical School for six weeks. He had never been to Africa, had very little understanding of the role of culture in mental distress, no knowledge about cultural belief systems in Malawi, and was intending to teach the same curriculum that he was currently teaching in the UK. It is worth considering how students in the UK would react to someone who came to teach with the same level of ignorance of local culture and circumstances.

Uganda

Maybe another country would be different! In 1995 I went to Uganda to research a possible innovative mental health project for a UK based NGO. While in Kampala I was asked to teach the psychiatric nursing students for a couple of sessions. In my discussions with them, the same appalling situation was revealed. While the students were aware and acknowledged that the majority of the population always consult a traditional healer for any kind of mental distress, and that the causation of mental illness is almost always seen in terms of the supernatural, they were expected to leave all their understanding about their own culture “outside the door”. There was no direct reference to their own culture through three years of training.

Belief and cure

It is generally accepted that even a placebo treatment can make someone feel better if s/he **believes** it is going to help. In that sense, a person’s beliefs about what has caused their problem/illness and what is likely to help them get better, are absolutely central to cure. Frank and Frank (1991) consider that what is viewed as an appropriate theory of illness and healing and the healing method itself are integral to any culture’s “assumptive world”, i.e the assumptions made by a culture to provide meaning and understanding of

phenomena. In relation to mental distress, these fundamental assumptions supply the person with a conceptual framework for making sense out of chaotic and confusing feelings, and suggest possible remedies.

For many people in “less developed” countries, the “assumptive world” of theories of illness and healing involves supernatural powers, ancestors or being bewitched in some way. There are mental states that may have no equivalent in other cultures, and mental and bodily symptoms are far less clearly differentiated than in the North. If this assumptive world is accepted and understood, then it is clear why the powers of a traditional healer would be considered essential for the treatment of mental problems. Frank and Frank (1994:101) state that “naming something is the first step towards controlling it”, but that “name” has to be something that has meaning within someone’s underlying assumptive world, otherwise it is actually meaning – less. Any understanding of illness is completely embedded within a particular society’s ways of making sense of the world. Thus the West’s medical model approach to mental illness will most often be considered just as irrelevant in “developing countries” as understanding of mental illness as being possessed by spirits would be considered irrelevant within the scientific framework of the North.

Characteristics of healing

However, in spite of enormous cultural differences, certain characteristics of the process of healing appear to be relevant to all cultures. The elucidation of such parallels would seem to be the foundation for attempts to formulate non-damaging help. Thus Frank and Frank’s (1991) features of the healing relationship are outlined in detail. Any healing relationship within any culture would seem to include the following:

- An emotionally charged, confiding relationship with a helping person (often with the participation of a group)
- A healing setting
- A rationale, conceptual scheme or myth that provides a **plausible** (my emphasis) explanation for the patient’s symptoms and prescribes a ritual or procedure for resolving them
- A ritual or procedure that requires the active participation of both patient and healer, and that is **believed by both** (my emphases) to be the means of restoring the patient’s health.

Case Study

Sreiber (1995) outlines in detail his attempts to treat an Ethiopian woman who had recently arrived in Israel. He describes her initial presentation of seemingly acute asthma attacks. The woman also described “hearing voices” telling her “bad things” and said she had a “snake in her leg”. She was diagnosed as suffering from an acute psychotic episode and treated with medication. There was no improvement after a number of weeks and

Schreiber describes how later it became clear, after many discussions with someone in her own language, that she was suffering a complex bereavement reaction to the death of her baby during the journey to Israel. As she had been unable to perform the culturally appropriate cleansing ritual after having contact with a corpse, the woman and her family considered her to be “unclean”. After considerable research into what would be appropriate, healing finally took place through an Ethiopian traditional healer who, in conjunction with her family, organised a traditional purification ritual in the River Jordan.

This illustrates graphically how the woman’s symptoms were initially misunderstood using a Western psychiatric model, which was not appropriate for **making sense** of her condition. Schreiber’s own capacity to put aside his initial diagnosis and his struggle to discover a more appropriate cultural paradigm with which to understand, is crucial. Healing eventually took place because the treatment made sense within the woman’s assumptive world. She **believed**, because of her own cultural belief system, that she was “unclean” and that the correct purification ritual would help her. It was administered by someone she trusted and who shared her belief in such a treatment. Thus, healing finally took place.

Principles of good practice

“Development aid is not an exact science: to date it has been riddled with misunderstandings, failed experiments and discarded theories . . . one of the most damaging aspects of the aid industry has been the tendency of donors to impose their own theories of what constitutes development on the recipients” (Slim & Thompson, 1993:10). What principles could guide aid from the North in the sphere of mental health so that it could be constructive, sensitive, and relevant rather than just another exercise in cultural imperialism under the guise of “aid”?

Listening

Although “listening” may sound an obvious principle with which to begin, it does not seem to happen automatically before “aid” is delivered. “The act of listening demands respect for the speaker . . . It needs the human skills of patience, humility, willingness to learn from others and to respect views and values that you may not share” (ibid: 3). Bennet (1996) describes “oral testimonies”, for example, gained by listening to Sudanese mothers’ beliefs when attempting to implement an immunisation programme for their children. Unsurprisingly, aid workers who spent time listening discovered that the mothers’ beliefs about what caused disease directly affected their understanding and acceptance of the programme. Thus, in mental health it would seem an essential first step to understand local beliefs about the causation of mental illness.

The role of indigenous language is crucial to this process. Not only is it a central commitment to listening to accept the idiom of the speaker, but it has

also been found (Gilbert, 1990, 1995, 1996; Munford, 1996; Patel et al, 1995) that some words describing mental distress in other languages are literally untranslatable into English, and that some common English words, such as “stress”, “anxiety” have no direct equivalent in other languages. A person’s sense of self has also shown to be radically different in different cultures and this has profound effects on thinking, motivation and the expression of feelings (Markus & Kitayama, 1991). However, through a very careful listening process, it could be possible to understand more accurately how mental distress is seen and experienced within a particular culture.

Integration in mental health training

Workers who have taken the trouble to listen carefully to the diagnostic systems of traditional healers have discovered far more common ground than would at first appear (Eisenbruch, 1990; Gilbert, 1995; Patel et al, 1995). Traditional healers make clear distinctions between drug/alcohol related conditions, family problems, psychotic states, neurotic problems and epilepsy. The attribution of cause and prescribed treatment may be completely different, but the differential diagnosis is almost identical. It seems to me that such understanding could form a bridge between the psychiatric student’s own cultural background and psychiatric approaches of the North. Thus the knowledge of indigenous practices and beliefs need not be abandoned in training, but would form an integral part.

Integration within the healthcare system

There is no doubt that some traditional practices, such as cutting the skin, are dangerous to the patient and increase the risk of further infections. In addition, traditional healers also sometimes interpret symptoms as resulting from personal or collective wrong doing; thus some of their treatments may contain elements of personal punishment. I consider that some psychiatric treatments used in the North, such as ECT (electric shock treatment) and the excessive use of drugs, are also harmful. If one took the view that any help in the field of mental distress needs to maximise what is helpful and minimise what is harmful, then perhaps the beginnings of a working synthesis may be established.

In many “developing” countries, people who are suffering from a psychotic disorder and who present a danger to both themselves and others, are often kept in chains because of the fear of their uncontrolled behaviour. Such psychotic conditions are however, often responsive to the psychotropic drugs used to control these conditions in the North. In the Mbarara Mental Health Programme in Uganda (Van Duyl, 1995) is an excellent example of collaborative working. It has been generally agreed that if the traditional healers cannot cure someone with a psychotic illness within two weeks then the person will be brought to the psychiatric ward. The psychiatrist has also agreed that outpatients most in need of “psychotherapeutic” approaches will be referred to a traditional healer. This close and mutually respectful way of

working recognises the suitability of drug treatments for some types of mental distress, but treatment takes place within the context of appropriate cultural understanding and in conjunction with traditional types of support.

This would seem to form the basis of mutually beneficial synthesis, but obviously can only occur if sufficient mutual trust, respect and support can be established. This programme was set up by a particular psychiatrist but, at the time of writing, traditional healers were not yet integrated into Uganda's health services.

Concluding comments

McCulloch's (1995) review of the history of psychiatry in Africa clearly reveals how it was completely entwined with the ideology of colonialism, i.e. the supposed superiority of Europeans over indigenous African peoples. Psychiatry in Africa reinforced and supported the colonial enterprise and was developed using the model of asylum already established in Europe in Victorian times. Thus there are still many asylums in African countries which were built in the early twentieth century and which are still often the mainstay of psychiatric services, for example the Zomba Mental Hospital in Malawi and Butabika Hospital in Uganda.

However, even though African countries are now politically independent, colonial attitudes are often pervasive, albeit more subtly, through the dominance of the market economic ideology of the North and the influence of global corporations on local politics. Traditional ways of living have been undermined and devalued as the ethos of consumerism, materialism and economic growth is promulgated as the only way for countries to "develop". Thus, millions of people have left the land and their traditional ways of life to seek work in the cities, resulting in the disintegration of existing family and community structures. Harpham (1994) and Harpham & Blue (1995) outline how increased exposure to Western influences and the adoption of urban lifestyles results in an increase in mental illness. Interestingly, this association had already been documented in the 1950s (McCulloch, 1995).

The content of the psychiatric nursing curricula in the African countries I have visited seems to suggest that cultural imperialism is still operating within the teaching and application of psychiatry. By presenting the medical model as the "only" approach to mental distress, local beliefs and traditions are implicitly devalued. Thus people, such as the student nurses, sometimes become "ashamed" of their own cultural beliefs and reluctant to admit to the role these play in their lives. Understandably, nurses can then experience great conflict when working in villages where traditional beliefs are completely accepted and traditional healers are considered the main source of help.

The incidence of mental illness in low income countries is likely to continue to rise as exposure to the ideology of the North increases, and traditional social structures disintegrate. If "help" for mental distress in these countries is to be relevant and sensitive to local cultures, it is imperative that greater efforts be

made to establish working syntheses across very different “assumptive worlds”. My own experience of designing a model for the teaching of psychiatry to student nurses, integrating both psychiatric approaches from the North and traditional approaches, and the close collaboration achieved by the Mbarara project in Uganda, shows that such working syntheses are possible. It would be tragic if increased funding for mental health projects simply furthered subtle cultural imperialism, rather than addressing the immense challenges of listening, recognising, and valuing difference and diversity, seeking parallels and similarities across different methods of healing, and actively working to establish co-operative, culturally appropriate mutually respectful ways of collaborative working.

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