Responding to mental distress in the Third World: cultural imperialism or the struggle for synthesis?

Jane Gilbert

A review of a report from the World Health Organisation published in the *New Scientist* (14 September 1996) asserts that by 2020 mental illness will be the most 'debilitating affliction' in the 'developing' world. Mental illness has come to prominence because WHO is now measuring the disabling effects of diseases using the DALY (disability-adjusted life-year) index, which focuses on loss of health rather than on mortality. A new WHO report usually generates considerable publicity and 'popularises' particular aspects of Third World problems. It is thus highly likely that this will be the consequence of the current report. Increased publicity for any such problem is very likely to generate increased funding. This paper questions the input that the West has already made to psychiatry in developing countries (particularly in Africa), examines some of the complex issues involved in working in the field of mental illness in other cultures, gives some personal observations from individual experience in Africa, and suggests some basic principles which could minimise the likelihood of Western aid in the field of mental distress being yet another example of thoughtless cultural imperialism.

'The idea of Development stands like a ruin in the intellectual landscape. Its shadow obscures our vision' (Sachs 1992:1). Many workers in the 'aid business' are now questioning the very bases of the ideas about 'development' that have coloured the West's approach to aid since World War II. Those issues cannot be discussed at any length here, but Sachs (ibid.) gives an overview of the main areas of controversy. What seems difficult for Western countries to acknowledge is that, in spite of 'aid', the problems of Africa continue to multiply, and the gap between rich and poor countries is actually greater now than it was 50 years ago. Questions are increasingly being asked about the role of global institutions such as the World Bank, the IMF, and international

business corporations; and the deleterious effects on ordinary people of the imposition of structural adjustment programmes as a prerequisite for the transfer of aid can no longer be ignored.

Given the questioning of even 'straightforward' aid projects, what are the prospects that the West might contribute good work in the field of mental distress? Thoughtless dissemination of Western culture and ideology has caused devastation in both ecological and human terms in many parts of the world. What hope is there that 'help' in the mental-health field will be more sensitive and thoughtful?

Mental illness and ideology

Mental disorder is found and recognised in all societies. However, how it is manifested in individual behaviour, what people believe causes the disorder, and what treatment is considered appropriate vary tremendously among cultures Although it has been found that some types of psychotic illness appear to have similar symptoms across cultures, other types of problem have been found to be 'culture-bound'. In other words, they are found in one particular culture only, and not in any other (Kirmayer 1989; Munford 1996; Patel *et al.* 1995; Witztum *et al.* 1996).

However, even when symptoms appear similar, *how* they are understood is totally dependent on the particular 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 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 systematically exported to Third World cultures, not simply value-free 'help'. (For a thorough analysis of the power relations involved in international 'help', see Gronemeyer 1995.) Although there may be dissent among professionals, the predominant Western model in psychiatry is the one 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 appropriate treatment, most often in the form of medication. The medical model is directly rooted in the West's emphasis on science as the preferred mode of 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 world-

wide 'universal' diagnostic system for mental disorder (Ben-Tovim 1985; Kirmayer 1991; Littlewood 1992; Patel and Winston 1994; Rhi *et al*. 1995; Sartorius *et al*. 1993; Weiss *et al*. 1995). In researching the literature, it seems surprising that this endeavour has been so persistent, in spite of increasing awareness of culture-bound syndromes and the reservations of many researchers who have attempted to use standardised classification systems (Edgerton and Cohen 1994; Littlewood 1992; Susser *et al*. 1995; Weiss *et al*. 1995).

'Our' kind of psychiatry: what can it offer?

Does the West's approach to mental illness and mental distress have anything non-damaging to offer 'developing' countries? In Western medicine, there is at least a broad consensus about the causation of physical disease and how it can be treated. Even though there is debate, it is generally agreed that people's bodies contain the same parts and work in the same way. However, there is far less consensus in the West about the treatment of mental distress. Many of its basic tenets, e.g. the biological basis of schizophrenic conditions, are completely rejected by other professional workers in the field (Marshall 1986; Boyle 1996). In mental-health services in Western countries, such fundamental disagreements are part of everyday life, even in the smallest psychiatric unit. Those 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. The disagreements among professionals continue unabated and show little sign of resolution.

Given the fragmented and disjointed nature of psychiatry in the West, what seems to have been exported to developing countries so far? What might the contribution of psychiatry be in the future, now that mental health is on the international aid agenda? The literature contains many studies of the incidence of mental illness in developing countries, and of validating measuring tools, but there appears to be very little about specific ways of working and what is actually happening. In considering the question of what the West seems to have exported already, I will draw on my own limited experience in Africa, although I recognise that the situation in countries with which I am unfamiliar may be very different.

Personal observations

The primacy of the Primary Health Care (PHC) team as a model of care in developing countries is now well established. It is generally

recognised that providing health services in the same way as the West is neither practically nor financially possible. Thus it falls to nursing staff to work at village level, dispensing medicines, training village health workers (VHWs), conducting health-education programmes, and in fact operating as the essential foundation for all health 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 (1991–1992), there was no psychiatrist in the country, and the medical input to the psychiatric in-patient unit was given by a general physician with no experience in psychiatry. The curriculum at the School of Nursing 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 vast majority of people with any kind of mental distress approached a *marabout* (traditional healer) before considering Western medicine. It seemed essential that I attempt to modify the curriculum to maximise the links between traditional approaches to mental illness and the Western model of psychiatry, as well as helping the students to research and integrate 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 there was no psychiatrist in post in the country. The psychiatry module in the curriculum at the Medical School contained no references to traditional beliefs, and the staff at the single national mental hospital (one being most humanely run by nursing staff in very difficult circumstances) focused almost solely on the administration of a limited supply of drugs. Chancellor College offered the only degree course in psychology in Malawi, the content of which has been extensively described elsewhere (Carr and MacLachlan 1993). It seemed to me to be saturated by Western ideology, and arrogant and patronising in its disregard for the local culture.

In 1996 I was contacted for a general discussion by a psychiatrist in Bristol who was volunteering to teach the psychiatry module in the medical school in Malawi for six weeks. He had never been to Africa,

had very little understanding of the role of culture in mental illness, and no knowledge about the cultural beliefs in Malawi; he was intending to teach the curriculum that he was currently teaching in Bristol. It is worth considering how UK citizens would react if someone from another country arrived and proposed to teach psychiatry in that way.

Uganda

Maybe another country would be different! In 1995 I went to Uganda to research a possible innovative mental-health project for Action on Disability and Development (ADD), a UK-based aid agency. While in Kampala, I 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 acknowledged and were fully aware that the vast majority of local people would 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 of their own culture 'outside the door'. There was no direct reference to their own culture throughout their three years of training. The head of the School of Nursing was aware of this anomaly, but stated that he had neither the choice nor the expertise to teach anything other than the required curriculum, i.e. the same as would be taught in the UK. When I asked the students how they would work in the villages when confronted with mental problems, they were uncomfortable and told me they would probably try to persuade people that their traditional views were 'wrong'.

Of course it is not like this in all African countries. In Zimbabwe, which I visited in 1995, great efforts seemed to be being made to acknowledge the place of traditional healers and integrate them into the health-care system (Patel 1995; Patel *et al.* 1995). There is also a somewhat belated recognition that this integration is essential for the newly emerging racially integrated South Africa (Freeman and Motsei 1992; Kale 1994; Straker 1994).

Belief and cure

It is generally accepted that a placebo treatment can make someone feel better if s/he believes it is going to help. In that sense, people's beliefs about what has caused their problem/illness and what is likely to help them get better is 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 mysterious feelings, and they suggest possible remedies.

For many people in 'developing' countries, the 'assumptive world' of theories of illness and healing involves supernatural powers, their ancestors, or being bewitched in some way. There are mental states that may not have a direct equivalent in other cultures, and mental and bodily illnesses are far less clearly delineated than in the West. 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 (1991:101) state that 'naming something is the first step towards controlling it', but that that 'name' has to be something which 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 as irrelevant in 'developing' countries, as the understanding of mental illness in terms of spirit-possession would be considered irrelevant within a Western scientific framework.

Characteristics of healing

However, in spite of enormous cultural differences, certain characteristics of the process of healing seem to be common to all societies. The elucidation of such parallels would seem to be the foundation of any 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 therapist, and that is *believed* by *both* (my emphases) to be the means of restoring the patient's health.

A very clear case study detailing all of the above can be found in Schreiber's (1995) description of attempts to treat an Ethiopian woman who had recently arrived in Israel. He describes her initial somatic 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 psychiatric episode and treated with medication. There was no improvement after a number of weeks, and Schreiber describes how it later became clear, after many discussions with someone in her own language, and his own consultations with an anthropologist, that she was suffering a complex bereavement reaction after the death of her baby during the journey to Israel. As she had been unable to perform the culturally appropriate cleansing ritual after having had 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 how the woman's physical symptoms were initially misunderstood through using a Western model which was not appropriate for making sense of her emotional distress. Schreiber's own capacity to put aside his initial diagnosis, and his struggle to discover a more appropriate cultural paradigm with which to understand, are crucial. Healing eventually took place because the treatment made sense within the Ethiopian 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 whom 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 and Thompson 1993: 10). What principles could guide Western 'aid' in the sphere of mental health so that it could be constructive, sensitive, and relevant, rather than simply another exercise in cultural imperialism?

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' (Slim and Thompson: 3). Bennett (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 essential as a first step in any kind of intervention to understand local beliefs about the causation of mental illness.

The role of indigenous language is crucial to this process. Not only is there a central commitment 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 English words describing common mental states in the West—for example 'stress', 'anxiety'—have no equivalent in other languages. A person's 'sense of self' has also been shown to be radically different in different cultures, and this has profound effects on cognition, motivation, and the expression of emotion (Markus and Kitayama 1991). However, through a very careful and thorough listening process, it could be possible to understand how mental distress is seen within a particular culture.

If listening were considered the fundamental guiding principle, then devising ways of integrating traditional and Western approaches becomes the next task, given that each can learn from the other.

Integration in 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, 1994; Gilbert 1995; Patel *et al*. 1995). Traditional healers make clear distinctions between drug- or alcohol-related conditions, family problems, psychotic conditions, neurotic problems, and epilepsy. The aetiology and treatments may be completely different, but the differential diagnosis is almost identical. It seems to me that this kind of

understanding could form the essential bridge between Western psychiatry and the psychiatric student's own cultural background, thus preventing the systematic abandonment of indigenous knowledge and practices.

Integration within the health-care system

There is no doubt that some traditional practices, such as cutting the skin, are dangerous to the patient and increase the risk of other 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 there are Western practices, such as excessive use of drugs or ECT, that are also harmful to patients. If one took the view that any help within the field of mental distress needs to maximise what is helpful and minimise what is harmful, then perhaps the beginnings of a working synthesis might be established.

In many 'developing' countries, people who are suffering from a psychotic disorder are often kept in chains because of the fear of their uncontrolled behaviour. (I have seen this in both The Gambia and Uganda.) Such psychotic conditions are often responsive to Western medication. In the Mbabara Mental Health Programme in Uganda (Van Duyl 1995), collaborative working with traditional healers has progressed to such an extent that 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 those who present as out-patients and seem most in need of 'psychotherapeutic' approaches will be referred to a traditional healer. Regular meetings with traditional healers are now established, although unfortunately the continued funding of this project is uncertain. This close and mutually respectful way of working recognises the suitability of Western drug treatments for some types of mental distress, but this 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 an excellent way of working, but obviously can occur only if sufficient mutual trust, respect, and support can be established. This programme was set up by a particular psychiatrist, but traditional healers are not yet officially integrated into Uganda's health services.

Concluding comments

McCulloch's (1995) review of the history of Western 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. 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 instance the Zomba mental hospital in Malawi, and Butabika hospital in Uganda.

However, even though African countries are now politically independent, colonial attitudes are still often pervasive, albeit more subtly, through the dominance of the Western market-economy ideology and the influence of global corporations on local politics. Traditional ways of living have often been undermined and devalued, as the ethos of Western 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 and Blue (1995) outline clearly how increased exposure to Western influence and the adoption of urban lifestyles results in an increasing incidence of mental illness. Interestingly, this association had already been documented back 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 Western medical model as the only approach to psychiatric problems, 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 that these play in their lives. Understandably, nurses may then experience great conflict when working in villages where traditional beliefs are completely accepted and the traditional healers are considered the major source of healing.

The incidence of mental illness in Third World countries is likely to continue to rise as exposure to Western ideology increases, and traditional social structures gradually disintegrate. If 'help' for mental

distress in 'developing' countries is to be relevant and sensitive to local cultures, it is imperative that greater efforts be made to achieve working syntheses across very different 'assumptive worlds'. My own experience of designing a model for the teaching of psychiatry to student nurses which attempted to integrate both Western and traditional approaches of mental illness, and the close collaboration being achieved by the Mbabara Project in Uganda, show 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.

References

Ben-Tovim, D. (1985) 'DSM III in Botswana: a field trial in a developing country', *American Journal of Psychiatry* 142(3): 342–44.

Bennett, O. (1996) 'Listen with mother', *The Health Exchange* October 1996: 10–11.

Boyle, M. (1996) 'Schizophrenia: the fallacy of diagnosis', *Changes* 14(1): 5–13.

Carr, S. and M. MacLachlan (1993) 'Asserting psychology in Malawi', *The Psychologist* 6(9): 408–13.

Edgerton, R. B. and A. Cohen (1994) 'Culture and schizophrenia: the DSM III challenge', *British Journal of Psychiatry* 164: 222–31.

Eisenbruch, M. (1990) 'Classification of natural and supernatural causes of mental distress', *Journal of Nervous and Mental Disease* 178(11): 712–15.

Eisenbruch, M. (1994) 'Resources and Limitations in Meeting the Mental Health Needs of the Cambodian Population', paper presented at conference 'Mental Health Education for Medical Doctors in Cambodia', Phnom Penh.

Frank, J. D. and J. B. Frank (1991) *Persuasion and Healing*, Baltimore: Johns Hopkins University Press.

Freeman, M. and M. Motsei (1992) 'Planning health care in South Africa: is there a role for traditional healers?', *Social Science and Medicine* 34(11): 1183–90.

Gilbert, J. (1990) 'Traditional Healers and Mental Health', unpublished report, Banjul: Gambia College, School of Nursing and Midwifery.

Gilbert, J. (1994) 'A Gambian experience', *Changes* 12(3): 165–9.

Gilbert, J. (1995) 'An Encounter with Dr Serwadda', unpublished report, Frome: Action on Disability and Development.

Gilbert, J. (1996) 'The Expression of Emotion: A Cross-cultural Perspective', Workshop, Keele University.

Gronemeyer, M. (1995) 'Helping', in W. Sachs (ed.) *The Development Dictionary*, London: Zed.

Harpham, T. (1994) 'Urbanisation and mental health in developing countries: a research role for social scientists, public health professionals and social

psychiatrists', *Social Science and Medicine* 39(2): 233–45.
Harpham, T. and I. Blue (eds.) (1995) *Urbanisation and Mental Health in Developing Countries*, Aldershot: Avebury.
Kale, R. (1995) 'Traditional healers in South Africa: a parallel health care system', *British Medical Journal* 310: 1182–5.
Kirmayer, L. J. (1989) 'Cultural variations in the response to psychiatric disorders and mental distress', *Social Science and Medicine* 29: 327–9.
Kirmayer, L. J. (1991) 'The place of culture in psychiatric nosology', *Journal of Nervous and Mental Disease* 179: 19–28.
Littlewood, R. (1992) 'DSM IV and culture: is the classification internationally valid?', *Psychiatric Bulletin* 16: 257–61.
Markus, H. and S. Kitayama (1991) 'Culture and the self. implications for cognition, emotion and motivation', *Psychological Review* 98(2): 224–53.
Marshall, J. R. (1996) 'Science, "schizophrenia" and genetics: the creation of myths', *Clinical Psychology Forum* 95: 5–13.
McCulloch, J. (1995) *Colonial Psychiatry and the African Mind*, Cambridge: Cambridge University Press.
Munford, D. B. (1996) 'The "Dhat syndrome": a culturally determined symptom of depression', *Acta Scandinavica* 94: 163–7.
Patel, V. (1995a) 'Working with traditional healers in Harare', *Psychiatric Bulletin* 19: 315–16.
Patel, V. (1995b) 'Spiritual distress; an indigenous model of non psychotic mental illness in primary care in Harare, Zimbabwe', *Acta Scandinavica* 92: 103–7.
Patel, V., F. Gwanza, E. Simunyu, I. C. Lloyd and A. Mann (1995) 'The phenomenology and explanatory models of common mental disorder: a study in primary care in Harare, Zimbabwe', *Psychological Medicine* 25: 1191–9.
Sachs, W. (ed.) (1992) *The Development Dictionary*, London: Zed.
Sartorius, N., C. Kaelber and J. E. Cooper (1993) 'Progress toward achieving a common language in psychiatry', *Archives of General Psychiatry* 50: 115–23.
Sartorius, N., T. B. Ustun, A. Korten, J. E. Cooper and J. van Drimmlen (1995) 'Progress toward achieving a common language in psychiatry II', *American Journal of Psychiatry* 152(10): 1427–37.
Schreiber, S. (1995) 'Migration, traumatic bereavement and transcultural aspects of psychological healing: loss and grief of a refugee woman from Begameder County in Ethiopia', *British Journal of Medical Psychology* 68: 135–42.
Seymour, J. (1996) 'Wake up call for world's health', *New Scientist* 14 September.
Slim, H. and P. Thompson (1993) *Listening for a Change*, London: Panos.
Straker, G. (1994) 'Integrating African and Western healing practices in South Africa', *American Journal of Psychotherapy* 48: 455–67.
Susser, E., V. Varma, S. Malbotra, S. Conover and X. Ainamdor (1995) 'Delineation of acute and transient psychotic disorders in a developing country setting', *British Journal of Psychiatry* 167: 216–19.
Thornicroft, G. and N. Sartorius (1993) 'The course and outcome of depression in different cultures: ten-year follow up of the YMO collaborative study on the assessment of depressive disorders', *Psychological Medicine* 23: 1023–32.

Van Duyl, M. (1995) 'Mental Health Rehabilitation Programme', unpublished document, Mbarara: Oxfam.

Weiss, M. G., R. Raguram and M. Channabasavanna (1995) Cultural dimensions of psychiatric diagnosis: a comparison of DSM III R and illness explanatory models in South India', *British Journal of Psychiatry* 166: 353–9.

Witztum, E., N. Grisaru and D. Budowski (1996) 'The "Zar" possession syndrome among Ethiopian immigrants of Israel: cultural and clinical aspects', *British Journal of Medical Psychology* 69: 207–25.

This paper was first published in Development in Practice *(9/3) in 1999.*