

Cross cultural perspectives on the medicalisation of human suffering.

Derek Summerfield

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The roots of contemporary mental health practice go back to the valorisation of reason and science ushered in by the European Enlightenment. The search for scientific accounts of the mind and its disorders started from Cartesian assumptions that the inner world of the mind had a realm separable from the outer world of the body, and was available for study in a comparable way. With this came an assertion of the causal nature of psychological events and a reliance on positivism to guide theory and research on the singular human being as basic unit of study. Psychiatric science sought to convert human pain, misery and madness into technical problems which could be understood in standardised ways and which were amenable to technical interventions by experts. Psychiatric knowledge was to be understood as neutral, objective, disinterested and universally applicable (Bracken, 2002).

Illich (1975) saw the secularisation of life in Western society, a waning of the power of tradition and religion, as an essential pre-condition for this philosophical development. Human suffering, until then accepted and explained as the will of God, had become a problem for scientists to solve, an undesirable condition. Thus a major feature of 20th century Western culture- gathering pace in the last 2 decades- has been the way that medicalised ways of seeing have displaced religion as the source of everyday explanations for the vicissitudes of life, and of the vocabulary of distress. The impact of violence and other morally shocking types of suffering are now framed through the (morally neutral) sciences of memory and psychology (Hacking, 1996).

There is nothing quintessential about a particular traumatic experience. The attitudes of wider society (which may change over time) shape what individual victims feel has been done to them and the vocabulary they use to describe this, whether or how they seek help, and their expectations of recovery. The more a society sees, for example, the trauma of rape (which generally refers not to physical trauma but emotional trauma) as a serious risk to the present or future health and well-being of the victim, the more it may turn out to be. In other words, societally constructed ideas about outcomes, which include the pronouncements of the mental health field, carry a measure of self-fulfilling prophecy.

Personhood and the focus on emotion.

Underpinning the constructs of, say, "mental health" or "trauma" is the concept of a person. This embodies questions such as how much or what kind of adversity someone can face and still be "normal"; what is reasonable risk; when is acceptance or fatalism appropriate and when a sense of grievance; what is acceptable behaviour at a time of crisis, including how distress should be expressed and help sought, and whether restitution is due. Western citizens now of older age grew up in a society that emphasised stoicism, composure and self-sufficiency. Broadly speaking a person, adult or child, was assumed to be reasonably resilient in the face of life's vicissitudes (Summerfield, 2001).

But ideas about personhood do not stand still. When a psychiatrist or psychologist attests that an unpleasant but scarcely extraordinary experience has caused objective damage to a psyche, with effects that may be longlasting, a rather different version is being posited. In what is in many respects a momentous shift, the concept of a person in contemporary Western culture now emphasises not resilience but vulnerability (Pupavac, 2001). There is a focus on emotion as the touchstone of personal authenticity, a reflection of the "real" person, but also a cultural preoccupation with emotional trauma and the language of emotional deficit. What has been described as a culture of therapeutics has demonised silence and stoicism, and invites people to see a widening range of experiences in life as inherently risky and liable to make them ill. This involves a blurring between unpleasant but everyday mental states and those suggesting a clinical syndrome. The conflation of distress with "trauma" has acquired a naturalistic feel, part of everyday descriptions of life. Terms like "stress" and "emotional scarring", which like "trauma" started out life as metaphors, have hardened (the concrete thinking of a technocratic age!) into actual entities signalling candidature for professional help. So too "low self-esteem", which has acquired extraordinary explanatory power for problems at any stage of life, and as a point of reference for education policy. One telling pointer to these trends comes from newspaper citations. A search of 300 British newspapers in 1980 did not find a single reference to self-esteem; in 1990 there were 103 references but in 2000 no less than 3,328. Citations of "trauma", "stress", "syndrome" and "counselling" all rose by 10-20 fold during the 1990s (Furedi, 2004)

An expansive mental health industry has in effect promoted the idea that the trials of life represent noxious influences easily able to penetrate the average citizen, not just to hurt but to disable. This is to endorse a much thinner skinned version of a person than previous generations would have recognised or respected. People are

educated into accepting that experiences like bereavement, receiving the diagnosis of a serious medical condition, marital problems, bullying, sexual harassment (even if only verbal), having an overbearing employer, giving birth and many others (the list grows) may well require professional intervention even when the person concerned has lived a competent life to date and has never demonstrated vulnerability to mental disturbance. Medically authenticated "stress" or "work stress" is now epidemic, the number one cause of sickness absence in Britain (Wainwright & Calnan, 2002). Increasingly the workplace is portrayed as traumatogenic even for those just doing their jobs- ambulancemen, police officers, soldiers, teachers and others now sue their employers on the grounds that they acquired PTSD on duty, presenting it as an industrial injury akin to pneumoconiosis in coal miners.

It is because medicalised and psychologised thinking is now so embedded in popular constructions of "common sense", and in the aesthetics of expression, that not to automatically use the language of trauma can make it sound as if what someone has gone through is being minimised. Thus it is instructive to review responses to a disaster a few decades ago in the light of what would have happened today. In 1966, in a tragedy that shook the nation, a coal waste tip engulfed a school in a Welsh village called Aberfan, killing 144 schoolchildren and teachers. There was no counselling and the surviving children resumed school 2 weeks later so that their minds would be occupied. There were no demands for compensation and the victims' relatives refused to pursue a prosecution against the National Coal Board or Government because this would have seemed vengeful. A child psychologist noted some months later that survivors appeared normal and well-adjusted, and newspaper reports commended the villagers for rehabilitating themselves so admirably with little outside help. After such an incident today, the assumption would be that survivors were inevitably deeply traumatised- some for life-and needed the expert intervention of an army of counsellors and other professionals (Furedi, 2004).

The phenomenal rise of "trauma", both as cultural idiom and as psychiatric category, may be linked to the emergence of this expressive and individualistically minded version of personhood, connected to the hopes and fears of modern life. We live in brittle times, with social vitality dependent on ever widening patterns of consumption (which include commodified "health"), requiring identification of new needs and desires. A nation is judged as if it was primarily an economy rather than a society and the lexicon of commerce increasingly regulates social relationships and responsibilities. The gap widens between winners and losers. On the one hand the "modernisation" of society has seen a loss in the binding properties of its fabric, and on the other there has been a promotion of personal rights and the language of entitlement. This climate fosters a sense of personal injury and grievance, and a demand for restitution, in situations that would formerly have been experienced as bad luck and the ordinary trials of life. It has been argued that the concept of honour (which is oriented outwards towards social roles and community) has given way to the concept of dignity (oriented inwards towards an autonomous self). There has been a withering of our belief in the comfort of religion or other transcending meaning systems, including politics. Has this eroded our belief in a coherent and ordered world, and left us feeling on our own? If so, unpleasant experiences, which we now label "traumatic", may be more likely to leave us shaken and doubting. PTSD seems a tailor-made diagnosis for an age of disenchantment or disillusionment. (Summerfield, 2001; Bracken, 2002)

Medicalisation and iatrogenesis

The medicalisation of life denotes the growth of the use of ideas about illness and disease to make sense of everyday experience. As medicalisation has grown, so too has the number and authority of its practitioners. In Britain the total number of consultant psychiatrists has doubled in 22 years, despite the closure of many of the old asylum-based psychiatric institutions. There has been a 50% increase in the past 5 years in the number of clinical psychology staff, and a tripling in 10 years in membership of the British Association for Counselling (Appleby, 2003). In 1962 the USA spent 4.5% of its gross national product on health, 8.4% of GNP in 1975 and is projected to spend 17% of GNP (\$2815billion) by 2011. In Britain more than 2.7 million people of working age- 7.5% of the working age population- are now claiming doctor-attested disability benefits, more than treble the number in the 1970s. Can the population really have grown so much more unhealthy? What has been described as a steadily mounting epidemic of low back pain and resultant work incapacity seems to reflect a greater willingness by people to report pain and to see themselves as incapacitated and requiring sickness certificates. Rising unemployment rates and changes in social security provision have doubtless also played a part (Croft, 2000).

Medicalisation is also driven by an emphasis on instrumental reasoning: a particular experience is judged as a function of the quantifiable effects held to flow from it. In relation to claimsmaking, it is not enough to have distress, one must have disability- a medical category.

In Britain the number of prescriptions written for anti-depressants rose from 9 million to 21 million during the 1990s, yet can anyone seriously argue that this merely reflects better recognition of a true epidemic of depression? (Double, 2002). The rise is even greater in USA- a near doubling in the last 5 years- mirroring the production and marketing of SSRI anti-depressants. The first edition of the Diagnostic and Statistical Manual (DSM) of the

American Psychiatric Association, in 1952, carried 104 psychiatric categories; the fourth edition of 1994 had 357. In this edition the stressor criterion for PTSD was widened so that second hand shocks now counted and many more people were diagnosable. It has been argued that as many as 1 in 4 of the US population could at any time be diagnosed with one or another DSM category: is this remotely meaningful? DSM categories are the products of vested interests, a major use being communication with insurers and other third parties. The American Psychiatric Association reportedly makes US\$60 million per year from selling DSM.

There is persuasive evidence that the pharmaceutical industry is in a position to set research agendas and to promote expensive treatments for non-diseases. Industry strategies include casting ordinary processes as medical problems (eg baldness), casting mild functional symptoms as portents of serious disease (eg irritable bowel syndrome), casting personal or social problems as medical ones (eg social phobia), casting risk factors as actual diseases (eg osteoporosis), and using misleading disease prevalence estimates to maximise the size of a medical problem (eg erectile dysfunction) (Moynihan et al, 2002). Some commentators see the pharmaceutical industry as having influential segments of the psychiatric profession virtually in its pocket. For example, there is a clear association between sponsorship and reported findings in research on anti-depressants. Published studies sponsored by the manufacturers of SSRI anti-depressants favoured these over other (and much cheaper) anti-depressants significantly more often than did studies sponsored in other ways (Baker et al, 2003).

How much extra "health" or "mental health" have these endeavours produced? Are there as yet uncounted costs? Clinical iatrogenesis is the injury done by ineffective or toxic treatments: a 1999 US Institute of Medicine report estimated that about 100,000 Americans a year died from preventable errors in hospitals. But this is not all. In a brilliant and prophetic analysis, Illich (1975) described the pervasive but largely unrecognised consequences of what he called social and cultural iatrogenesis. Health care consumed an ever growing proportion of the national budget, and with unclear benefits for patients or society as a whole. Above all, he pointed to the implications of a longer term destruction of time honoured ways of dealing with pain, sickness and death. Can we observe this today? The more the mental health field promotes its technologies as necessary interventions in almost every area of life, the more people pick up that they are not expected to cope through their own resources and networks, the more that socioculturally constructed ways of enduring and coping may wither. As more resources are provided for mental health services, more are perceived to be needed - an apparently circular process. Has the mental health industry become as much a part of the problem as of the solution?

Western psychiatry and psychology: universally valid knowledge?

The globalisation of the Western order continues apparently irresistibly, accompanying the huge and widening disparities of power between the dominant institutions of the West, and those of the rest of the planet. Western ideas about suffering and its antidotes have been globalising too: what claim to universal validity do they have? In its development Western psychiatry has tended to naturalise its own cultural distinctions, objectify them through empirical data and then reify them as universal natural science categories (Littlewood, 1990). This is an achievement but it is not a discovery. There are many true descriptions of the world and what might be called psychological knowledge is the product of a particular culture at a particular point in its history. Western psychiatry is merely one among many ethnomedical systems. Thus it is depressing that, to give but one example, an editorial in a major psychiatric journal can still maintain that "there is no solid evidence for a real difference in the prevalence of common psychiatric disorders across cultures" (Cheng, 2001). The socioculturally determined understandings that people bring to bear on their active appraisal of their predicament, and on their expressions of distress and help-seeking, are here being regarded as mere packaging. The (Western) psychiatrist is to see through this packaging to the psychopathology within, which he knows to be universal and the "real" problem.

All of psychiatry is culture-bounded, not just a few exotic syndromes in the DSM or ICD. Organic brain disorders might seem most obviously to refute this statement - because of their biological basis - but even they will present in ways shaped by local lifeworlds and forms of knowledge. A psychiatric diagnosis is generally handled by doctors, by the medicolegal system, and indeed by wider society, as if it was synonymous with a disease- but it is not. The ICD and DSM categorise phenomenological constellations but this is not synonymous with scientific validation. A diagnosis carries no deeper understanding of what is really wrong. In this respect Hacking (1996) quotes the nineteenth century philosopher Whewell, who noted that it was easy to generate true statements about a dog, but who could define a dog? A diagnosis can be seen as a point of reference, a way of seeing, a style of reasoning, and in compensation suits and other claims-making- a means of persuasion.

These classifications are also not atheoretical and value-free - for example, they contain ontological notions of what constitutes a real disorder, epistemological notions of what counts as scientific evidence, and methodological notions about how research should be conducted. They are contemporary cultural documents par excellence (Mezzich et al, 1999).

The psychiatric literature on the application of quantitative research methods to non-Western settings largely founders on the rocks of what Kleinman (1987) called a category fallacy. The fallacy is the assumption that because phenomena can be identified in differing social settings, they mean the same thing in those settings. The histories of terms like "depression" or "post-traumatic stress disorder" (PTSD), and the particular meanings (and responses) they mobilise in contemporary Western culture, are simply not straightforwardly reproduced elsewhere. There is no equivalent to these terms in many cultures (Pilgrim & Bentall, 1999). The history of depression reveals the gradual incorporation of the Western cultural vocabulary of guilt, energy, fatigue, and stress (Jadhav, 1996). Thus depression or PTSD as they stand simply cannot be universally valid diagnostic categories. Yet the World Health Organisation (1996) is claiming that "depression" is a worldwide epidemic that within twenty years will be second only to cardiovascular disease as the world's most debilitating disease. This is a serious distortion, which could serve to deflect attention away from what millions of people might cite as the basis of their misery, like poverty and lack of rights. The UN Food and Agriculture Organisation says that the number of chronically hungry people in the world is rising by 5 million a year. The one clear-cut beneficiary would be the pharmaceutical industry, with its vested interest in the biologisation of the human predicament.

Many ethnomedical systems have taxonomies that range across the physical, supernatural and moral realms, and do not conceive of illness as situated in body or mind alone. The body is seen to be susceptible to the actions and wishes of ancestors, and to spirits. Distress is commonly understood and expressed in terms of disruptions to the social and moral order and internal emotional factors are not seen as able to cause illness (Kirmayer, 1989). The Western individual is seen as disengaged and free to the extent of being fully distinguishable from the natural and social worlds. If a patient's cultural background attributes more importance to causation than to the presenting clinical features, DSM categories, which work the other way, may violate that person's state of mind (Eisenbruch 1992).

Higginbotham and Marsella (1988) studied the impact of Western psychiatry in Southeast Asia, noting a number of unanticipated and indirect effects: professional elitism, institution-bound responses to distress, and undermining of local traditional healing systems. Psychiatric universalism risks being imperialistic, reminding us of the colonial era when what was presented to indigenous peoples was that there were different types of knowledge, and that theirs were second rate. Sociocultural phenomena were framed in European terms and the responsible pursuit of traditional values was regarded as evidence of backwardness. Said (1993) noted that a salient trait of modern imperialism was that it claimed to be an education movement, setting out consciously to modernise, develop, instruct and civilize, echoing the earlier writings of such as Cesaire and Fanon on the surreptitious incorporation of the ideologies of colonial dependence and racial inferiority into modern psychological discourse.

Personhood and emotion in non-Western worlds

My intention is not to cast "culture" as a monolithic bloc, nor to efface the differences between citizens of a particular society that relate to social or economic status, education, and urbanisation. However, the dissemination of Western mental health practice introduces elements that are not mere surface phenomena but core components of Western culture: a theory of human nature and development, a definition of personhood but also of "childhood" and "family", a secular source of moral authority, a sense of time and a theory of memory. As already noted, any discussion about mental health or ill-health cannot but invoke the concept of a person current in that cultural setting. Consider the emphasis Western personhood gives to a deep, hidden, private self, and to emotion and vulnerability as I described above. How congruent is this with non-Western definitions, in which the self is largely interpersonal and consensual, more orientated to key roles and relationships than to what is deeply private. Social connectedness, not personal depth, is the measure of the moral value of the self. In many cultures the harmony of the family or group matters more than the autonomy of the individual who is not conceived of as a free-standing unit. Indeed many African languages have no word for the self. Thus containment of emotion and adaption to social circumstances are viewed as signs of maturity.

Cultural worlds may differ so dramatically that translation of emotional terms means more than finding semantic equivalents. Describing how it feels to be aggrieved or melancholy in another society leads directly into an analysis of a radically different way of being a person (Kleinman & Good, 1985). A culture that does not embody a dualistic view of individual and "society" will have little time for the very category of "psychological states", and for the distinction between "emotion" and "cognition". (Ingleby, 1989).

As an example, for Somalis, emotional experience and expression are understood- by the individual concerned and by those around him or her- primarily in terms of what they say about sociopolitical, not intrapsychic, processes. This does not mean that an individual psychological dimension is not recognised, merely that the organising framework is collective and sociopolitical rather than medicopsychological. Their distress, particularly anger, is a communication about a moral injury, an appeal for validation and practical action (Zarowsky, 2000).

The globalisation of "trauma"

The most spectacular facet of the globalisation of Western trends towards the medicalisation of distress has been the "trauma" discourse. Over the past 15 or so years this has reshaped the way the experience of war, atrocity or natural disaster anywhere has been seen (in the West), and responded to as a health or humanitarian issue. Expansive claims by Western health professionals- many working as consultants to UNICEF, WHO and other major agencies- have promoted the idea of war as a sort of public mental health emergency, and of "post traumatic stress" as a "hidden epidemic". "Trauma" has become a point of reference in Western countries for the appraisal and reception of asylum-seekers from war zones

I have critiqued at length elsewhere the assumptions underpinning the globalisation of "trauma" as a supposedly valid and relevant framework for capturing and addressing human response to extreme events (Summerfield, 1999a). Put briefly, these assumptions are that the experience of war routinely generates not just suffering or misery but "post-traumatic stress", a pathological condition affecting large numbers of those exposed and who need attention for this; there is basically a universal human response to such events, captured by the PTSD model; Western mental health technologies are universally valid, and victims do better if they "work through" their experiences; timely intervention can avert later mental disorders, violence and wars. All these assumptions are highly problematic and the last one is preposterous.

In this new language, the emotional reactions of people affected by war are perceived as harmful to themselves ("traumatised") or as potentially dangerous to others ("brutalised"). War-affected children are commonly portrayed as "brutalised", and thus likely to grow up and start new "cycles of violence" in vengeance. This paints a picture of damaged psychologies and moral norms, of diminished humanity. UNICEF (1996) has stated that "time does not heal trauma" for millions of such children, who are often described as a "lost generation". The medical literature is replete with similarly sweeping statements which lack validity, and are pathologising and stigmatizing. They seem a form of medical imperialism. Moreover these subjects have not given consent for their mental lives to be objectified (typically from afar) and characterized as unhealthy: this seems an ethical question (Summerfield, 2002).

Studies of non-Western asylum-seekers in flight from violent conflict, seen in clinics in Western countries, have been highly prominent in the cross-cultural mental health literature in recent years. Yet it is in clinical work that the lack of coherence and generalisability of the PTSD model is apparent at close range. PTSD criteria distinguish poorly between the physiology of normal distress and the physiology of pathological distress, so that overdiagnosis is easy (Summerfield, 2001). To give as an example the work of a much published authority in the field, Mollica et al (1998) compared a group of Vietnamese refugees with a history of torture, newly arrived in USA, with a control group of non-tortured Vietnamese refugees recruited in the local community. 90% of the tortured group satisfied criteria for PTSD but so did 79% of the control group. Questions of validity and explanatory power came through strongly in a personal series of over 800 asylum-seekers or refugees, most with a history of torture or other forms of political persecution, whom I assessed as principal psychiatrist at the Medical Foundation for the Care of Victims of Torture, London, during the 1990's (and in previous research on war wounded ex-soldiers and peasant survivors of atrocities in Nicaragua). Using PTSD checklists, a considerable proportion of these might have been diagnosable as "cases" but this was belied by their capacity to function. Whilst there were a few whose despondency had dulled them to their immediate situation (and who merited more attention) the vast majority were as active and effective as the opportunities in their new environment allowed. They were upset but not ill.

To understand this better we need a nuanced view of the construction of psychiatric facts in the clinic. Firstly, what a patient brings to a medical setting is what he sees as appropriate to bring to such a setting. This generally means bringing symptoms. What he presents may not be what is troubling him most, or indeed at all, but it allows engagement with the doctor and what may flow from this. This is especially relevant to the asylum-seeker, for whom medical services are an early point of reference. This leads on to the demand characteristics of the medical interview itself. The asylum-seeker may have picked up that doctors are interested in the psychology of those who have survived war and other disasters, and that particular questions tapping psychology are asked regularly. He wants to be interesting and intelligible to the doctor, for he hopes for an ally or advocate with authority at a time when his social situation is precarious. Thus the questions put to him become important precisely because it was the doctor who asked them. There would be additional medicalizing impetus if the asylum-seeker understood that his answers to the doctor's questions could form the basis of a psychiatric report in support of his asylum claim. The interview might elicit, say, low mood, disturbed sleep or jumpiness, and in some cases a request for sedatives or sleeping tablets. But for many others, these features would be understandable by-products of their situation, and not what they were attending to- if we define a symptom as basically something a patient complains of, these were not symptoms but epiphenomena.

Thus the process by which the answers to a doctor's questions are rendered up as "symptoms"- potential contributors to a psychiatric diagnosis- is as much the product of the mindset of the doctor as of the patient. It does not follow that the asylum-seeker's attitude to or handling of his mood, sleep or edginess when at home, or at the refugee community centre, would be the same as it is formulated in the clinic. In a psychiatric interview the doctor is looking for patterns, and especially if he is primed by the assumption that survivors of traumatic events generally carry psychological effects (a cultural assumption, as outlined above), he is likely to find what he is looking for. For my part I found that a diagnosis of PTSD in particular was poorly predictive of an individual's capacity to pay the psychological costs of what had happened, to function well despite hardship and to keep going, nor a reliable indicator of a need for psychological treatment.

Medicalised constructions of the experience of war posit an unduly mechanistic view of human experience, one that suggests that the traumatic effects of war are to be found inside a person (between his or her ears), and that a person recovers as if from an illness. In fact there is a singular dearth of data suggesting that mental health morbidity is higher in populations exposed to war or other complex emergencies than in those not exposed. One interesting example is Northern Ireland, since it is one war zone where comprehensive health records covering the last 30 years of civil conflict are available. During this period there has been no evidence of significant impact on referral rates to mental health services (Loughrey,1997). Indeed several million civilians in Europe were exposed to events during World War Two which would have rendered them liable to "post-traumatic stress" by the standards applied in Bosnia, Rwanda and other conflict zones, let alone Western civil society in recent years. So where did this veritable epidemic go to?

We must realize the limitations of a discourse in which the effects of collective violence and social upheaval are represented as individual illness and vulnerability. The medicalisation of distress entails a missed identification between the individual and the social world, and a tendency to transform the social into the biological (the mere machinery of the body). The objectification of understandable distress or misery as a pathological entity apart ("trauma") - a technical problem to which short term technical solutions like counselling apply - is a serious distortion and for the vast majority "post traumatic stress" is a pseudocondition. This is not of course to play down what people may suffer, but suffering is not psychopathology. There is little evidence that those affected anywhere in the non-Western world have seen their mental health as an important issue apart, and wanted treatment specifically for this.

The fundamental relativity of human experience, even in extreme conditions, and the primacy of the subjective appraisal and social meaning, means that there can be no such thing as a universal trauma response. Human responses to aversive experience are not analogous to physical trauma: people do not passively register the impact of external forces (unlike, say, a leg hit by a bullet) but engage with them in an active and problem-solving way. Suffering arises from, and is resolved in, a social context, shaped by the meanings and understandings applied to events (and which may evolve as the context evolves). It is subjective appraisal that determines what a stressful event means: one man's trauma is another's heroic sacrifice. Health professionals have a duty to recognize distress, but also to attend to what the people carrying this distress want to signal by it. War affected populations, for example, are largely directing their attention not inwards, to their mental processes, but outwards to their devastated social world. They know that they will stand or fall by what they do in and about that world. For them the key question is not "how am I feeling?" but "what can I do to bolster my situation?" The refugee literature highlights the pivotal role of family and social networks in exile. In Iraqi asylum-seekers in London, current poor social support was more closely related to low mood than was a history of torture (Gorst-Unsworth & Goldenberg, 1998). In the longer term it is socioeconomic and sociocultural factors that are major determinants of outcomes. Is the suffering of the world's hungry and undernourished children less of a "trauma" than that occasioned by bombs and bullets? (Summerfield, 1999b).

Medicotherapeutic ways of seeing assume moral and political neutrality. But all suffering evokes questions of values and morality, and the experience of war and social upheaval is bound up with notions of responsibility, accountability and restitution. Medicotherapeutic interventions will not work when a morally blind technical fix is besides the point. There is no evidence that victims of such events, even in Western cultural contexts, do better if they undergo counselling to emotionally ventilate their experiences (Wessely et al, 1998). The very idea of Western talk therapy or counselling, with its focus on detached introspection, is alien in most non-Western cultures.

In perhaps the first ethnographic account of its kind, Argenti-Pillen (2003) queries whether imported Western trauma work could contribute to a destabilization of culturally specific forms of postwar organisation in southern Sri Lanka. She describes a linguistic discourse of "caution" engendering a particular flow of knowledge about past violence, and which acted to curtail cycles of violence. "Cautious" talk used euphemism, indirect and imprecise speech, and minimised accusation. A folk ailment like "terrified heart" was only ambiguously attributed to human

agency, and was treated by ritual cleansing ceremonies. Following the arrival of 30 nongovernment mental health organisations promoting Western-type counselling, "terrified heart" was liable to be recast as a war-related illness ("trauma"), with implications for a much less "cautious" understanding of events and their legacy. Elsewhere the notion that "traumatic stress" causes psychological disruption may be invalid in cultures that emphasise fate, determinism and spiritual influences. We need more ethnographic work of this kind in other parts of the world (like Rwanda) where imported trauma programmes and counselling have had high profile.

The problem of human pain and "recovery".

Human pain and suffering, and how it was to be understood, has always been central to the relationship between human consciousness and the material world. In the twentieth century, orthodox psychological science sought to conceptualise this conundrum as ultimately residing in the way the brain was wired and memories stored. The meaningful nature of reality was seen in cognitivist terms, as something arising from programmes or schemas running in individual minds. It is questionable how much such systems can capture universal truths about distress and suffering when they largely ignore the sociocultural and situational forces which shape the active appraisal a particular subject brings to bear on what has happened. There is an ethical dimension to this. (Bracken & Thomas, 2001).

There are dysfunctionally distressed and mad people in every society, and local forms of understanding, accommodation and healing. To assert this is not to assume that such forms are at all times humane and effective, that "culture" can always cope. There may be aspects of Western psychiatry or psychology, including medication, which are useful in some situations. The problem is the overall thrust that comes from being at the heart of the one globalising culture. It is as if one version of human nature is being presented as definitive, and one set of ideas about pain and suffering (which, after all, are ideas that go to the heart of the human condition). It becomes ever harder to properly acknowledge difference and diversity, and not just pay lip service to it. It would be a wiser and truer use of the term "psychology" to define this as an expression of a background intelligibility comprising a system of thought and practice based on the day-to-day behaviour and points of view of the members of a particular group or people. There is no one definitive psychology.

It would carry us rather further to see meaning not as software in an individual mind, but as something generated through practical engagement with the world- through a lived life with all its complexity and capacity for multiple interpretations. These influences are not merely secondary, as Western psychological thinking asserts, but the very stuff of this background intelligibility against which distressing experience can be set (Bracken, 2002).

Psychiatry and Psychology cannot use their methodologies and ways of thinking to critique their methodologies and ways of thinking. To get "outside" the problem we need a much broader sweep. Human pain is a slippery thing, sitting in sociomoral and philosophical domains which themselves are variable and slippery. Nowhere, no more in Western societies than elsewhere, is it straightforwardly subject to technical interventions in isolation from other aspects of life. This point seems ever more resonant at a time when, as I outlined earlier, Western culture has moved towards a view of the human condition defined by vulnerability, with "emotion" as the currency, and towards the professionalisation of everyday life. Ironically, in such an environment it may be harder to reconcile to the losses and pain, to life as a vale of tears, which is part of our common lot.

Health professionals should beware the limitations of looking at the world through a Medicotherapeutic prism. The idea that "recovery" from an aversive experience (or "processing" or "healing" or "closure") is a discrete thing is again a legacy of the Cartesian assumptions that launched psychiatry and psychology- that the mental world is separable from the material world and can be instrumentalised separately. In the real world "recovery" is even more slippery than "suffering", and as subject to sociomoral and philosophical considerations. Its setting is people's lives rather than their psychologies. It is an unspectacular and even banal matter, grounded in resumption of the ordinary rhythms of everyday life- family, sociocultural, religious, economic- which make the world intelligible. Perhaps the imperatives of life leave little choice, that this is the lesson of history (Summerfield, 2002). Naturally this is not to say that simply getting on with life ablates the suffering that has come from one experience or another. What people may carry in their hearts, or indeed take to their graves, is another matter- indeed some would see it as morally important (where there have been terrible events) not to "recover" or "come to terms with it". Such trajectories are not typically visible from the clinic: tracking them is the work of historians, sociologists, journalists, poets, religious and political leaders, and via the output of the actors themselves.

To conclude, the Western mental health field can seem to propagate a rather misanthropic view of mankind- as more or less damaged goods- and to neglect the sensibilities essential for more humanistic perspectives. This would be to see human nature- for all its inconsistency and ambiguity- as basically sturdy and resourceful, and as tending towards intelligent and progressive responses to the trials of life.

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Derek Summerfield
Honorary Senior Lecturer, Institute of Psychiatry, King's College, London.
Research Associate, Refugee Studies Centre, University of Oxford.