Ordering Madness for the Social Organization of World Mental Health:
An Institutional Ethnography

by

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ABSTRACT

This thesis explores how research about mental health services is part of the social organization of international development. Institutional ethnography is used to explicate the social relations of the work of 'World Mental Health'. Data analysed include the author's personal experience in West Africa as a development worker in community mental health services. The inquiry is a textual analysis of a survey called a "Pathways Study" that the author implemented to support her funding requests from international aid agencies.

The argument made is that the "Pathways Study", beyond being a source of information for aid agencies, is part of a ruling relation. Its implementation and use inserts a 'World Mental Health' framework into a local setting where it disorganizes local mental health efforts. The survey reconstructs what is known about the setting into concepts that match dominant Western (banking, scientific, professional and corporate) ideas and interests. The author suggests that through the systematic official process of privileging certain discourses, texts and approaches, local perspectives are subordinated.

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Introduction

From 1996 to 1999 I worked as an international development worker in The Gambia, West Africa. I discovered myself to be an 'alien', a foreigner in local terms, where interpretation and translation became a visible and important part of my everyday world in the field as a mental health nurse. In that time I worked as part of a team to develop a budding community mental health service. I also found myself, an experienced community nurse, in an administrative role very foreign to me. I was working to access funding, support, supplies, and a place for mental health on the agenda of those planning and funding health services. My four Gambian nurse colleagues and I worked with a commitment to respect the local beliefs of causation and treatment of mental ill health. We employed a community approach to our work given the community orientation and extended family systems of Gambian society. My encounters in the clinical arena were inspiring, dramatic and sometimes troubling. I was especially puzzled by how my clinical work, what was actually happening in mental health care, and my work in the realm of advocacy and administration were seemingly disconnected. It became apparent to me there were two distinct but disconnected modes of knowing mental health: local and official.

The disconnection became most apparent in my last few months as I prepared to hand-over my leadership of the CMHT (Community Mental Health Team) to local Gambian colleagues and attempted to secure sustainable funding through the government's Five Year Health Action Plan that was to be supported

through loans from The WB (World Bank). In preparation of this plan for mental health, I was asked to write reports to describe our work. I found myself struggling to find the 'language' that could be both honest to our experience and effective in meeting our needs for supplies, staffing and new services. Certain language and reporting was clearly 'better' and encouraged by the government administrators of our mental health programs. In addition to our routine data collection, I also participated in coordinating and collecting data for a study, 'The Pathways Study', that was intended to supply needed information to secure required resources. During this work, I found myself thinking that The Gambia and other poor countries need a qualitatively different kind of help with the development of health care services. What they were getting, through international aid and the resources of the national World Health Organization Office, including that with which I was assisting, seemed better than nothing; but there was also a critique to be made. This study takes up that critique, not a definitive critique of mental health orientated development work, but an exploration of the troubles that arise in 'helping' and doing development work cross-culturally. This research is an inquiry into what happens 'on the ground' when global organizational strategies and technologies are applied to describe local experiences and problems.

Back in Canada, I began the course of study that led to this thesis research partly because of my own desire to make sense of the new perspectives, feelings and experiences I encountered while working with the

CMHT. A sense of contradiction between my everyday experiences of mental health care in The Gambia and my understanding of the concerns of the dominant funding agencies also motivated me to analyze and reflect upon my experiences. I wanted to understand how I was implicated in this work of organizing mental health services and to deepen my understanding of the problems and potential of working across differences. A fundamental drive to deepen my understanding of the contradictions and of how to share my stories about working across cultures in a meaningful, purposeful and respectful way also prompted my research.

In my research, I set out to explore what was happening along the fault line of my experience in knowing the mental health situation as we lived it and then as we wrote it up for research and official records. I wanted to understand more fully how this fault line came to be, what exactly was happening, and how this disjuncture fit into a larger picture. What I discovered was a language of organization that provides both global order and local disorder. Both local and official ways of knowing mental health care shape and are shaped by the other, to construct a view of progress in 'World Mental Health'[1] that I claim is incomplete, ideological and troublesome.

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[1] 'World Mental Health' is a term I use to describe the conceptualizations of mental health and frameworks for mental health services constructed by a conglomerate of actors within the World Health Organization, World Bank, and academic and corporate settings internationally. This term is further developed in Chapter Two.

As I made these discoveries I began to question how the interests of those involved in constructing what is know about 'World Mental Health' privilege certain dominant Western interests over local interests. Through textual analysis, I argue that doing the 'The Pathways Study' was transformative of the mental health work that my colleagues and I did in The Gambia. I also argue that the study translated local knowledge and local practices into concepts that have special meanings with what I have come to call the 'World Mental Health' framework. This is a framework or schema I identify conceptually as the organizations weaving together what is currently understood to be important for mental health services internationally. Through my analysis I now see that economic agendas for western progress/efficiency and biomedical research objectives are at the centre of how mental health work becomes palatable for those researching and administering services in developing countries. I began to query how the interests being served in this process might be primarily those of the extra-local academic, international lending agents and the biomedical corporations involved. The 'development' of the discursive 'World Mental Health' thus appears illusionary or, possibly more fittingly, delusional.

My research is presented in six chapters. In Chapter One, *"The Problematic Modes of Knowing",* I familiarize the reader to the setting. As well, I describe the foundational notion of the 'problematic' that is the impetus for this thesis work. Within this first chapter I narrate, in detail, how the problematic of the inquiry arose out of my experiences as a Community Mental Health Nursing

Officer working in The Gambia attempting to bridge two modes of knowing (local and official). I reflect on my troubles in having to report on our mental health service activities, needs and statistics in expanded and new ways in pursuit of administrative support for sustainable growth of the CMHT (Community Mental Health Team).

Chapter Two, *"Discourses on Mental Health and International Development"*, examines the discourses on development and what I call the 'World Mental Health' framework. This framework sets out research agendas, education designs, treatment and funding practices and is advanced by primary donors for mental health programs (namely The WB -World Bank and WHO - World Health Organization). I query the unquestioned dominance of these discourses on the actual mental health work in The Gambia. I also point to the paradox of a 'World Mental Health'; that somehow in our complex, diverse world there could be one model of mental health care, one that requires a biomedical approach to study it and ultimately to diagnose and provide treatment.

In Chapter Three, *"Methodology: Out of the Discourses and Into Something More Comfortable", I* discuss institutional ethnography, the methodology used in my research. This feminist methodology, which fits within the constructivist paradigm, enabled me to study my own experience as data, understanding it by discovering the relations of ruling in which my experiences in The Gambia were situated. In my inquiry I analyzed my experiences, my observations and texts of 'The Pathways Study'. This chapter outlines the

concepts (standpoint, experience, social relations, ruling relations, and text as elements of social organization) and particular analytic techniques (exploration of the "activation of text" and "text-reader conversation") that direct my textual analysis in the terms of institutional ethnography.

In Chapter Four, *"The Pathways Study Construct of Meaning: Thinking Globally and Acting Locally",* I explore the 'translation' of local circumstances and needs into a common language of 'psychiatry' in 'The Pathways Study'. This survey was used in The Gambia to document some of the presenting symptoms, 'pathways' of care and treatments in our mental health service during the course of one month. My analysis explores the ways in which 'The Pathways Study' and the survey instrument itself structured our understanding of patients' experiences. I argue that as we worked with the survey, our practice changed towards using 'psychiatry' as an interpretive frame. Here I discuss how the transformation of local experiences into the official terms of psychiatry accomplishes the work of extra-local agents for purposes of ruling.

Chapter Five, *"Textual analysis of the study: The construction of 'delays' ", invites* a glance at the meaning embedded in the text of 'The Pathways Study'. Through analyzing the text, I show how the textual construction of 'delays' in Western psychiatric referral offers mental health clinicians an interpretation of what mode of treatment is considered 'appropriate' for the mentally ill. This analytic work makes meaning of 'The Pathways Study' with the organization and discourse of the dominant 'World Mental Health' framework at the foreground. I

argue that the notion of 'delays' taught us as practitioners to understand what was an adequate response to the people attending our clinic. I also argue that this construction further accomplishes the work of the 'World Mental Health' framework to promote 'efficiency' and productivity for international development.

Chapter Six, *"Stepping Out of the 'World Mental Health' Framework And Into Another Standpoint",* summarizes my conclusions. Overall, this concluding chapter expands on those ways in which dominant Western world ideas are penetrating the assistance given to The Gambia for improving mental health services. I discuss how the imposition of the global mental health framework works to suppress local knowledge on behalf of the capitalist enterprise. I also suggest that this imposition of 'World Mental Health' as ideology has been taken for granted as a benefit to development and mental health care internationally. From the foundation of my experiences, I contend that my concern is to offer a different standpoint on the assumed benefit of a 'World Mental Health'. Finally, as I conclude, I reflect on the ways in which my experience in The Gambia has changed my practice as an educator, researcher and international development worker. This is a story that has taken me from the dusty, earthy, messy place of my experiences, through these six chapters, and back again to my new work with nursing students, some of whom I am preparing to visit West Africa and elsewhere in the so-called 'developing' world. The insights I have gleaned about the practice of dominance as I experienced it extend far beyond my time in the Gambia and are shown to be generalized

practices of dominance expressed through policy and practice.

Chapter One

"The Problematic - Modes of Knowing"

Knowing and Not Knowing: An Alien in Africa

From August 1996 to August 1998 I worked as a Nursing Officer for the Department of State for Health in The Gambia. I had been recruited through an international non-governmental organisation, VSO (Voluntary Services Overseas) at the request of the Gambian government who were in need of technical assistance to fill my position and develop staff to take it over. In this position, I was in charge of a team of four Gambian nurses who were developing and implementing a community mental health service. There are few theoretical or practical 'road-maps' for such a developing service. Much of the evolution of the CMHT (Community Mental Health Team[2]) was, at first glance, pragmatic and seemingly community based. Working in this cultural, religious, political and environmental climate I had to suspend nearly all of my previously held beliefs about how to communicate, teach/train, manage and work clinically as a mental health nurse. There is nothing so bold as the cultural bath of a new environment to awaken one's senses and shift one's previously held perspectives.

Blending a Western clinic-style of mental health care with local values, systems of community health work and culture was always interesting,

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[2] The Community Mental Health Team was a team established in The Gambia by the Gambian government in the early 1990's with the technical assistance of expatriate volunteers through Voluntary Services Overseas.

compelling and challenging but never an easy split of consciousness. Smith (1990) refers to this "bifurcation of consciousness" as the "experience of moving between two modes of working, with a working consciousness active in both" (Smith, 1990a, p19). I had a glimmer of the consciousness of local life and the glimmer of the Western orientated mental health models and modes. I could see that both had important and different places in our mental health work, however, finding ways to work across the different modes was never an easy task.

My identity in The Gambia made me simultaneously an insider and an outsider as I worked with the CMHT. I am only beginning to appreciate now how the lenses with which I viewed The Gambia, 'development', and mental health work, and others and myself were so layered with the conflicting ('insider' and 'outsider') constructs of reality. I carried into my work in The Gambia the values of the voluntary sending agency that recruited me for my job with the Department of State for Health. These values instructed me to live and work under the same conditions as my national colleagues. The premise of this way of working is that sharing life experiences and ways of living facilitates the sharing of skills (VSO, 2001). I was a white, English speaking, educated professional in this predominantly black West African and Islamic population. I experienced myself as someone who was called an 'alien' in local languages. I understood that to be an identity constituted by British colonialism in The Gambia, which was marked by a history of internal conflicts and differences. My alienation existed by the very nature of this history, my connection with VSO (an

agency funded predominantly through the British Department for International Development), and my privileged Canadian freedom to travel, work overseas and return to my comfortable life in Canada when my term was up. The distinct privilege of the citizenship of my birth afforded me the luxury and opportunity to work in another culture for two years, an opportunity that would be almost impossible for my nursing colleagues in The Gambia. For them even getting a work visa to volunteer or work in Canada or elsewhere would be a significant obstacle. Although I was in this regard, an alien (a privileged foreigner) I attempted to live up to my VSO commitment by working and living alongside my Gambian colleagues. My salary and accommodations were similar to my work-mates and I gradually found myself adapting to working with the tools and resources available locally for our mental health services.

I mainly learned 'on the job' how to take on this new role in very uncharted territory. Notes and conversations with my VSO predecessors, Gillian and Donna, guided me greatly, and my Gambian colleagues and friends were an endless source of learning, moment by moment, as we worked. We worked with what resources we could find at the time and with whatever medical and operational supplies were available (however inconsistently). The few textual resources available on international mental health programs (mostly distributed through The WHO) soon became our CMHT's guiding lights. Though these textual supports did exist to support our work, they provided little help with the many logistical challenges that surfaced. We had limited financial resources and

training opportunities for staff. Other daily constraints in our work included: a lack of stationary and record-keeping materials, a troubling shortage of fuel and the routine appropriation of our trekking vehicle for other needs of the State.

In the two years that I worked in The Gambia, mental health services continued to evolve from acute care facilities, located in the capital city, to a decentralized program countrywide. At the community level we journeyed upcountry, on what we called 'treks', to conduct clinics, identify new patients and follow-up with previously treated patients. During our treks we worked with all of: local healers (who were locally called 'marabouts'), district health teams in the six districts of the country, village level health workers and the country's two schools of nursing. I helped to design and implement in-service training for village level workers and community health nurses. As a team, my colleagues and I also provided pre-service training and instructed psychiatric nursing courses with the state registered nursing school, enrolled nursing school and community health nursing school.

My responsibilities were diverse and included: supervision of staff, teaching and training, program development (in community mental health nursing), administration and much fundraising. I provided supervision and management of the service as our program was moved administratively from the acute care hospital to the Health Promotion and Protection Division of the Department of State for Health. My role as the Nursing Officer was also evolving. I needed to integrate the CMHT program with the acute care hospitals

and the central government departments (central statistics, maternal/child and primary health care directors). My fundraising role was more internationally focused. International aid agencies, the United Nations (UN) bodies, World Health Organization, other international donors and the diplomatic core were among my contacts in this complex business of development work.

As the CMHT program was developing and changing, I reflected on the delicate balance of my commitment to the spirit of working alongside locals and attending to local practice while still being part of 'development'. I was conscious of my alien status when I reflected on the right actions to take with our programs. While I was committed to respecting local norms and values, I was still there to do a job, to help develop our community mental health services and to bring a certain level of expertise. In many ways a tension existed in terms of what expertise, if any, *I had* to offer. It felt like I had to set aside many of my familiar practices and beliefs, yet I was unfamiliar with many of the local experiences and beliefs. I wasn't sure what I knew anymore, what was valid, useful or 'right'.

Experiences With Local Healing

On several occasions my colleagues and I would have very lively discussions when the topic of the predominant belief of spiritual causation of illness in The Gambia was raised. Marabouts were the first and preferred routes to treatment. Each village had marabouts (local healers) who were employed by villagers to assess social, physical and spiritual difficulties, and to create spiritual

protection or healing modalities. Treatments used inherited knowledge of botanical methods of healing indigenous to The Gambia, as well as words from the Koran and religious invocations spoken or drafted in the form of written prayers tied into leather pouches and worn as charms called jujus. Specifically assessing and treating mental health problems, were eight marabouts who operated compounds that served as care facilities for those in need. Financially, employing the services of marabouts was a sacrifice for the majority of people. Typically the cost of a course of treatment for a significant episode of mental ill health was a cow or bull (the equivalent value of one hundred US dollars). At the time I worked in The Gambia no systematic means of monitoring or registering this care or service existed. Though little information is documented about local African healing (Peek 1991, Horton 1998) our CMHT worked with marabouts and we sought to learn from them experientially while on our treks upcountry.

Most of my CMHT colleagues though educated and working in the Western psychiatric system, maintained strong spiritual beliefs, assessed our patients' social and spiritual perspectives of mental ill health, and themselves sought the counsel of marabouts. The discussions I had with my colleagues continued to raise my questions about the ideas and practices we were importing into our developing CMHT services.

In his studies of African belief systems, Peek claims "divination systems do not simply reflect other aspects of a culture; they are the means (as well as the

premise) of knowing which underpin and validate all else" (Peek in Eze, 1998, p172). I wanted to understand more about local beliefs of the causation of illness, treatment and healing practices in order to understand more about my colleagues' worldviews. To gain understanding I spoke with my colleagues, read from anthropology and African philosophy texts, and made a habit of observing and asking questions as I worked. West African spiritual beliefs provided an illuminating view of how patients, families and communities interpreted and cared for their mentally ill. For most African people, spirit ideation is the predominant theory of the cause of mental illness; it is a theory that does not deny so-called natural or empirical causes of illness, but seeks supernatural, though ultimately social, ones behind them (Castillo, 1998). This is an epistemology that Horton describes as "placing things in a causal context wider than that provided by common sense" (Horton, 1993, p184). The "wider" context I heard about from my colleagues and friends in The Gambia was something I often wrote about to friends and made notes of in my journal.

Spiritual causation of illness was described to me to manifest itself as an explanation for all kinds of misfortunes (frustrations in life, failure in love, lack of success in business or for losses or deprivations), and possibly even the cause of the presenting symptoms themselves. Anxiety, paranoia or apprehension were said to be generated by the spirits that occurred in various types. Some of the spirits I heard about from patients were said to be those that were inherited and would appear as familial mental illnesses. It was described to me that the spirit

has an extended lifespan that must attach itself to a human to live through the generations. Another type of spirit was said to represent itself as controlled by human wishes, both benevolent and malevolent. I felt a deep and profound need to take these beliefs into account when considering treatment and care that would be culturally appropriate and sustainable in The Gambia. African spiritual notions of disease causation I encountered in The Gambia are also described by Horton (1998) as spiritual agency moved by visible, tangible happenings in the social world. I sought to learn as much as possible about African philosophies and beliefs before beginning my work across cultures while in The Gambia. Horton's (1998) writings reveal some of that cultural bridge I sought as I worked. He writes:

> If life in modern industrial society contains sources of mental stress adequate to causing or exacerbating a wide range of sicknesses, so too does life in traditional village communities. Hence the need to approach traditional religious theories of the social causation of sickness with respect. Such respect and readiness to learn is, I suggest, particularly appropriate with regard to what is commonly known as mental disease. I say this because the grand theories of Western psychiatry has a notoriously insecure empirical base and are probably culture-bound to a high degree. (Horton, 1998, p184).

I was fascinated, and occasionally frustrated, by attempting to work across these distinct worldviews - African and Western. Amidst the confusion of African spirituality and Western psychiatry, I felt a huge responsibility to do good work to expand care and treatment to those patients suffering and often physically restrained for years due to mental illnesses. I also wanted to take

actions that would be respectful of local needs. I began to raise questions about my role as an 'alien', or agent of these foreign ideas of mental health work. Different ways of knowing 'mental health' were visible but confusing to me.

While in the face of these conflicting beliefs and ways of knowing, I had much more to learn about development work as well. I had development work to do and I was responsible for improving mental health practice in the community in The Gambia. While I was learning the local views of spiritual belief/practice, my colleagues in the CMHT and I were also learning new ways of helping patients from each other. In my role as a leader for our team, I was drawn into Western, scientifically based textual resources and notions about health. International resources guided our learning about program development, integration of 'traditional' practices into Western systems of health care and community work. We would seek out literature wherever we could on whatever we needed to know. Still, much of our learning was from first hand experience.

I began to see dimly how my work was being influenced by these incongruent but dominant Western ways of seeing and making meaning. I began to see in a very immediate way that a spirit of volunteerism, good intentions and hard work were not sufficient for me to successfully make a case for the funds, services and staffing we required for our practice. There were implicit rules and expectations for successful fund-raising and program development about which, at the time, I was only partially aware. The differences between the local and extra-local ways of knowing and helping left

me increasingly torn and disconnected.

The Contradictions of Helping: Knowing as local and outsider

I will not soon forget my first weeks working in The Gambia. The contradictions in the culture seemed so marked. On one side of a street in the capital of Banjul, I could observe a woman in traditional brightly coloured cloth wraps, carrying large buckets on her head, a baby tied to her back, and several other baskets in her arms. On the other side of the street I could just as easily observe a woman in a European styled suit, talking on a cellular phone. These frequent and visible contrasts set the stage for the many glaring contrasts and contradictions in mental health treatment and training I was to encounter.

The community mental health team I joined had been working for four years with two preceding expatriate VSO Nursing Officers at the helm prior to my arrival. Two Gambian nurses were identified and received training in community mental health

nursing through a WHO funding program for education. They arrived back from the WHO training centre at a university in southern Africa just shortly before I joined the team. We also worked with two nursing assistants and had vehicle for our use, along with a driver who also became part of our team as we traversed far into the countryside into all corners of The Gambia. A core group of patients in communities countrywide was identified through this home-visit method. There was already a high demand for the care and services of the CMHT. When we would visit the up-country regions often there would be long lines of patients

to see, who were already identified in their communities as needing mental health care. Many home-visit or rural health centre clinic days were set up for us on these journeys. On my first 'trek' with the CMHT to the rural communities I was shocked at the situations we confronted. One patient's situation challenged the CMHT from the onset of upcountry 'trekking' in 1995 to almost the last months before my contract concluded. This patent was a thirty five-year-old man who lived in the Upper River Division (URD) on a compound where most of the males have migrated from the community to seek work elsewhere. In his youth he had been educated at high school and traveled in Europe. My journal of these initial findings on trek with the team continues to alarm me.

> ...Out of fear for the women and children of the compound, this man's leg was bolted to a log with a large metal bar over his ankle; nails attached this bar to the log. He sat naked and burned, having scarred himself with cigarettes and matches during his illness and the ten years he had remained restrained to this log. His hut was in disrepair - the roof nearly fallen in. (personal journal entry, 1996)

I realized within a few days of working with the CMHT that my training in mental health nursing had not prepared me for the work I was now doing. I acknowledged that I would have to modify almost everything I knew about community mental health from my training and experience for this drastically different environment. As an outsider I observed many shocking and troubling violations of the basic human rights of the mentally ill. I could easily see why, both locally and extra-locally, it was felt that something must be done to aid the plight of the mentally ill in this country. On the one hand I was compelled, as is

much of the international health community, to 'do something' to stop the neglect of the mentally ill and abusive treatment practices, to develop services and to aid the care of those suffering. I also recognized the strength of the local practices and practitioners, the sense of sustainability of locally available resources and technologies, and the fundamental beliefs around causation and treatment of mental anguish. The beliefs and respect for local healing methods that the nurses I worked with held, while not totally understandable from my position as an outsider, did begin to guide and influence me. I realized that in order to be effective in this work I would have to consider all of these complex, contradictory issues and find a way of integrating these worldviews.

As the team worked to integrate local needs, priorities and realities into a developing Western-oriented clinic service, we provided direct patient care, treated patients, and provided support and counsel to families. We also spent about a quarter of our time on other community based development activities. We organized campaigns to raise the awareness of mental health concerns in order to shift the stigma that resulted in the abuse or neglect of patients. Frequent projects and meetings with local health workers, artists and healers began to connect our work to the community in the integrative approach our team desired. To facilitate the integration, we met with community leaders, local actors, traditional singers and media, as well as the national health education committees and The WHO's national office. We were involved with the creation of a puppet play in the local languages with a popular communication group; we

conducted radio phone-in shows about mental health problems and a host of other local activities. The multiplicity of tasks was challenging and compelling, but the least of my worries, as I began to look at handing over my leadership of the team.

Efforts to Sustain CMHT Development:
'Knowing' for purposes of gaining needed supplies and support

In spite of the challenges, improvements were initiated through the work of many committed people over the years in establishing the CMHT. Over a seven-year period more staff received training and increasing numbers of patients received treatment (many being liberated from years of physical restraints). As a result of the changes and program growth, the acute care psychiatric treatment facility, located in the capital city, was able to discharge patients with a sense that ongoing follow-up, assessment and treatment would take place. New understandings of mental illness and treatment were being shared across the country. At one VSO program evaluation, the Director of Health Services for the Department of State for Health referred to the CMHT and its services as a 'success story'. The praise was considered a great compliment by the VSO Field Director in The Gambia, aware of the often-unsustainable work of international development projects. In spite of my own insecurity about aspects of the work, I felt that in general my team's work was successful in caring for the mentally ill and creating a coherent community mental health program for the country.

In my last months in The Gambia, having become well versed in the

development worker ethos of 'sustainable development', my mind turned towards the future of our community mental health programs. How would the CMHT be managed without another expatriate VSO technical assistant to follow me at the end of my term? Did the team have adequate staffing and the commitment of operational budgets in order to continue and expand? Would VSO be able to hand the programs over to the now trained and, in my eyes, extremely competent, and motivated Gambian nurses? Would the local staff have the same status in the eyes of the development sector donors, often suspicious of local requests? These questions and others both plagued and guided me during the transition phase of handing over leadership of the CMHT to the Gambian staff.

Attempting to secure training opportunities/funding, medication resources, operating budgets and special event resources for the CMHT before my departure, I drafted letters and reports to the director of our programs at The Department of State for Health. I was aware a 'Health Action Plan' was being composed in order to secure longer term funding from The WB/IMF (The World Bank and International Monetary Fund), primary lending agents for funding health services in The Gambia. The timing seemed right to get a focus on our services for long term planning and funding. Adequate supplies needed to be requested, staff training needed to be allocated and general program plans needed to be projected in the design of the Department's Five Year Health Action Plan. Based on this plan, loans and aid would be administered from official

sources outside of The Gambia, namely, The World Bank and The WHO.

Alongside my routine reports and requests, the director at The Department of State for Health continually made demands for more statistical information. commitments for resources required for the 'sustainability' of the CMHT and their programs seemed elusive. I had been recording our statistics and data in workbooks and reporting the information quarterly. I had arranged for the documentation of the data the CMHT collected at the Central Statistics Unit of Department of State for Health after discovering that unit did not have accurate accounts of our mental health statistics. Additionally, we had the results of a large needs assessment study from 1994 by a Nigerian visiting psychiatrist. In conversation with the health leaders in government however, I discovered that these usual and historic sources of data were not considered 'reliable' or useful by Department of State for Health officials. Through our usual documentation and reporting a number of decisions were to be made. I had to make sure the government and external-funding agents considered our requests and reports 'reliable' and appreciated the need for mental health services to be considered in the planning of budgets or loans. After having been so involved in the development work 'success story' of our CMHT, I was determined the team would have a sustainable future. As we worked towards this ending, the message from the central government continued to be that we needed better documentation on mental health issues. It was as though yet another report would somehow bring enlightenment. In spite of my frustration, my curiosity

was raised. Why was 'more and better' documentation needed?

Disjunctures in knowing: Local and official knowledge

The government requested more information from the CMHT in order to incorporate mental health into the Five Year Health Action Plan. This was a plan being constructing to access official aid programs of The WB/IMF. Judging by the demands on us for different and more accounting, it appeared The WB was placing different demands on the government to record numbers, diagnoses, treatment and training needs in new ways. On the suggestions of our director at The Department of State for Health and the chief statistician in the department, I approached The WHO regional office staff to look at how we could better document and record the magnitude of the mental health problems of The Gambia. This research and technical assistance was one of the roles of the national office of WHO in The Gambia. One program of study, in particular, was forwarded from The WHO's Geneva library in response to my requests for assistance. The program was recommended in the literature as it was considered the "corner stone" to further descriptive research: this was a study of referral pathways to mental health services. This was a 'pathways' study that looked at referral pathways to mental health services and could identify incidence of newly presenting illness.

The Gambia's WHO office could offer no funding for the collection of mental health data, though their administrators were very supportive of the idea of further documentation. The director of the national WHO office informed me

that their library resources, statistician and other assistance could be made available in our work of researching the mental health situation. I elected to pursue other funding resources through The Canadian Bureau for International Education, a program I was informed about by the Canadian Consular representing the Government of Canada in The Gambia. I proposed a study and obtained approval and funding to begin to document, in a methodical and scientific way, some of the mental health issues confronted by the CMHT. The Gambian office of the WHO and The Gambian Department of State for Health aided and approved my proposal writing as well.

My concerns about the sustainability of our mental health services persisted though it appeared we would have a place in The Gambian Department of State for Health's Five Year Health Action Plan. Our documentation efforts were increasingly propelling us towards that goal of recognition of mental health services by the Central Government's proposals for official aid and loans. I hoped this official recognition would facilitate longer-term sustainable development of the CMHT. Nevertheless, I continued to question why the 1994 needs assessment and the routine CMHT reports were not sufficient for planning training and mental health services in The Gambia. Had we wasted our time writing up all those reports? How was it that this information was overlooked and not seen as reliable or valid as compared to other information?

The Problematic of My Study

By being so directly confronted with a problematic, a puzzle about how it comes to be that certain kinds of knowledge are considered legitimate and others are not, I required an approach to direct my analysis through the difficult questions and puzzles I confronted. As I reflect on my experiences in The Gambia, I recall my unease with some features of my work. There are puzzles implicit in the social organization of the everyday world of the mental health nurses in The Gambia. I perceived a disjuncture between what my colleagues and I knew from doing mental health work and how that work appeared when it is 'reported' in studies organized by an international discourse, that is detached from the everyday working world of the nurses and patients in The Gambia. This disjuncture is the point of rupture Smith (1997) would refer to as the research problematic. The concept of the problematic arises from theoretical understandings I employ in my research (see Chapter Three), one that theorizes power and authority and their effects as "social relations of ruling" (Smith, 1999, p79).

Smith (1987) more fully characterizes the problematic of everyday life as the experience of incoherence and disorganization in the process of social relations at the abstracted level organizing and generating processes in the everyday world. In other words, life is interpreted and written up from the standpoint of those organizing that everyday world (the scientists, academics, managers, planners and so on). This interpretation then comes to step in for

how everyday life is understood. All the categories and frameworks that arise from this standpoint become the 'facts' of how life works. I experienced this disjuncture in The Gambia as I worked alongside nurses and patients and understood mental health from my experience on the ground, and then learned how it was 'properly' worked up and reported as research. I felt a sense of incoherence. The acceptable and official versions were different even than our own statistical accounts. The WHO model of research was an acceptable method of constituting 'mental health data'. Such a point of disjuncture in understanding one's everyday life is where Smith says the problematic of the everyday world resides.

The predominant treatment of our patients through local healing practices was happening in my everyday world as I worked in The Gambia. The nurses with whom I worked held onto much of this worldview, a view that I could only begin to understand in my two years working along side them. It puzzled me continually. What was my place in this? I was confused. Would I be 'helping' to direct our program with the kind of documented perspectives we had available through the WHO office? I wondered how the CMHT could best integrate the knowledge of WHO and the requirements of the WB without dismissing or disintegrating local knowledge?

My 'problematic' and my experiences with the CMHT and The WHO research frameworks became the point of entry, and the focal point, for this inquiry. I recognized that this problematic called for an approach to inquiry that

would enable me to see the way things worked as they did in this circumstance and to create a meaningful framework for the discussion. The purpose of an institutional ethnography is to "explore everyday life, not to theorize it" (Campbell and Gregor, forthcoming). As Smith states, "the everyday world is not fully understood within its own scope, it is organized by social relations not fully apparent in it" (Smith, 1987, p.92). Therefore, institutional ethnography proceeds on the understanding that the everyday world is socially organized. I wondered how we begin to understand this everyday, but very socially organized, world of mental health nursing in The Gambia? The disjuncture between knowing from experience and knowing for official (WB and WHO) purposes needed to be explicated so that local experience could be recognized for itself at the table of planning and prioritizing for mental health services.

Chapter Two

"Discourses on Mental Health and International Development"

In this chapter I introduce some of the important ideas and discourses that are used in understanding and managing mental health work in The Gambia and other developing countries that access international aid for mental health programs. The World Health Organization is the pre-eminent body that develops policy for health programs and I will explain how mental health is part of its mandate. The mental health discourse is vast. My interest here is to offer sufficient background on how mental health work is becoming conceptualized as part of a global undertaking to decrease poverty, increase capitalist productivity and trade. The World Bank and the International Monetary Fund are important players in developing discourse on the relation between mental health and improved productivity or 'Development'. This brings me to another contribution to the discourses that frame mental health work in developing countries - international aid agencies. As I will show in this chapter, these discourses are not entirely separate even though they originate in different organizations. Together they make up what I call a 'World Mental Health' framework, that, in the last section of the chapter I describe as I saw it being used, relied on and treated authoritatively at an international conference in July 2001. By conceptualising this framework I offer a glimpse inside the discourses of what is understood globally, versus locally, in mental health.

Discourses to Manage Mental Health

Development workers and researchers join with the organizers of development in managing and helping so-called 'underdeveloped' or less industrialized nations. A conglomerate of global forces and organizations including The WB, The WHO and WFMH (World Federation for Mental Health) is in charge of conceptualizing, planning, funding and directing mental health work. Development workers and researchers are assigned by these organizations to carry out their work in the 'developing' world. Following is my analysis of the institutional discourses that guide the work of each organization. Exploring the discourses on 'World Mental Health' and 'Development' helps me to understand how my experience in mental health work in The Gambia came to be organized as it was.

The WHO

This initial overview of The WHO's conceptualizations of mental health is a review of the central visions; goals and actions articulated in particular texts of The WHO. Specifically, I review the role of research as a plan of action for the 'World Mental Health' agenda.

The WHO is an international health institute initially forged to combat common threats such as plague, yellow fever, smallpox and other infectious diseases (WHOa, 2000). As the directing and coordinating authority on international health work, the WHO functions to:

> promote biomedical and health services research, promote improved standards for teaching and training of health professionals, to establish and stimulate international standards for biological, pharmaceutical and similar products, to standardize diagnostic procedures, and to foster activities in the field of mental health (WHOb, 2000, p1).

The WHO works closely with other organizations in The UN and in partnership with The World Bank and other bilateral agencies, intergovernmental and non-governmental organizations (WHOb, 2000, p5). A feature of the organization of The WHO is its decentralization into six regions. The assembly of The WHO that meets annually to set policy for the work of WHO. There is an executive board designated by a Member State elected to do so by the assembly. The assembly appoints a Secretariat, headed by the Director-General. All countries belonging to The UN may become members of The WHO by accepting its constitution. These nations, 191 in total, are divided into one of the six WHO regions and are assigned regional offices and national offices (WHOb, 2000).

Goals of The WHO include: "harmonizing legislation and terminology, and fostering the dissemination and exchange of information on these subjects" (WHOb, 2000). Contributions in health policies are designed to "reach beyond the health sector to constitute an integral part of sustainable development". Each of The WHO's working areas is said to reflect the reach for "equity and sustainable development". In doing so, "international and cross-sectional health partnerships" are to be forged to achieve "health for all". The functions of The WHO in achieving health for all are in four main areas: world-wide guidance,

setting global standards, strengthening national programs and developing and transferring technologies, information and standards. The notion of people assuming "responsibility for their own health" is also espoused in WHO documents (WHO, 1997, p2).

Specifically, mental health is classified in the category of non-communicable diseases although it is allocated its own division within The WHO. At the division level (including mental health) the following strategies are promoted:

> Comprehensive chronic disease control and the application of cost-effective methods of detection and management and major sustained global campaigns to encourage healthy lifestyles, healthy public policies and acceleration of research are promoted in the agency. (Brundtland, 1999, p3).

The WHO and Measuring Global Mental Health

Global objectives for mental health, treatment approaches, training and research are articulated in press releases, research reports and documents of The WHO (WHO, 1997). As I draw together a picture of the evolving framework for 'World Mental Health', I make particular note of the notion of "measuring the burden of disease" and the trend towards conceptualizing mental health problems in the framework of "Disability Adjusted Life Years" (DALYs) (Desjarlais et al, 1995, p5). The origins of such concepts are discussed and specifically drawn from The WHO Director-General's "New Global Strategies for Mental Health" (Brundtland, 1999). In her 1999 address, Dr. Brundtland unveiled new WHO Global Strategies for Mental Health and reported that the burden of mental

illness was among the most important contributors to the 'global burden of disease'. This burden is measured by the DALY, which was jointly clarified as a measure of overall burden of disease by The WHO, The World Bank and The Harvard University Medical School Department of Social Medicine and associates (Desjaralais et al, 1995). Special risk groups are identified and are to be targeted in this strategy. Specifically, The Director-General has identified depression and epilepsy as particular areas in which The WHO proposes strategies to improve treatment rates. Overall improvements in the promotion of "effective interventions and essential drugs to control diseases" were reported as key strategies along with general "monitoring of the mental health of the world" (Brundtland, 1999).

WHO: Mental Health Programs and Policy

Several models, quality assurance frameworks, and research goals/protocols have been developed over the years to bring into action the goals and conceptualizations of 'doing' mental health in the global context. Texts that are sources of the social relations of 'doing' mental health programs globally have evolved over time. Work within a global framework of mental health began in the 1960's with "The WHO's International Pilot Study of Schizophrenia". (Sartorious & Harding, 1987). This study grew over the period of 1966 to 1975. It was originally designed as an exploration into the universality of schizophrenia and other forms of psychosis and continually evolved using changing designs. Standardized assessment instruments, modern case-finding

techniques and the large scale (over 1200 patients) and comparative power (9 cities, representing both developing and developed countries) of the studies are discussed in many works (Sartorious and Harding, 1987). "The Determinants of Outcome of Severe Mental Disorder" (Harding, 1987) is one several follow up studies that explored treatment outcomes and built on the foundational Sartorious and Harding work. Later studies using general health questionnaire surveys further extended the earlier work. Sartorious et al's (1993) research expanded to cover fifteen sites internationally, surveying 5604 persons to produce a database to explore the nature of psychiatric disorders and disability over time. Other WHO research activities that evolved further aimed to look at the "quality of mental illness care available in community setting" (Gater et al, 1991). From these studies several standardized protocols for research were developed for the purposes of cross-cultural application and validation (Gater et al, 1991). Further to these historical developments, current objectives for mental health within The WHO report that:

> good epidemiological information is needed, information should be collected on systems and activities, data should be collected on concepts of well being, and research programs, tools and protocols should expand across sites. (Brundtland, 1999)

The WHO constructs a clear direction for development of mental health services. The researchers expanded and developed their work to construct a picture of assessment and treatment strategies. The direction points to system monitoring, multi-site programs and assessment tools such as those developed for mental

health in the 1990s.

Desjarlais et al (1995) found that dramatic changes in psychiatric approaches and research, like the developments noted above, have come to form the foundation for restructuring mental illness in a global, multicultural perspective. Classification systems have in turn increasingly become 'internationalized' to form a 'common language' for psychiatry. The Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD) are examples of internationalized instruments for the 'advancement' of psychiatry.

Mental Health Development and the Common Language of ICD-10

The WHO Program on Mental Health has had an increasing focus on the work of standardizing methods for assessment, diagnosis, classification and nomenclature of mental disorders (Westermeyer et al, 1997). The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines is said to represent:

> a significant advance towards the achievement of a common language for use by mental health professions worldwide. It has been developed and translated into many languages for different cadres of workers. Training materials, diagnostic instruments and other tools for research and implementation have been compiled to help facilitate the use of the classification. It is said by the working group in charge of the classification tools that precise definitions are necessary if they are to be capable of reliable use across cultures (Westemeyer et al, 1997, p).

A series of lexicons and glossaries have been developed to define the terms used in cross-cultural psychiatry in comparative research and the

application of ICD 10 in various cultural settings. A cautionary note is made on ICD-10 documents claiming that not all professionals will find terms to match their understandings of common terms or local understanding, but that a "working compromise is essential if a common language is to be established for purposes of communication" (Westermyer et al, 1997, p2)

WHO clearly takes a lead role in conceptualizing mental health, mental illness and its treatments, particularly in areas of the so-called developing world. Some of the concepts are articulated in strategic plans at the central WHO level and address the identification of target groups (epilepsy and depression) and remark on the magnitude of the problems by way of the DALY measure of the burden of disease (Brundtland, 1999). The articulation of such definitions into the diagnostic categories of the ICD-10 (WHO, 1993) is refining the complex nature of creating priorities and programs for mental health care globally (Desjarlais et al, 1995). Definitions and central concepts are brought into practice and activated through research that is continuing to develop and advocates a cross-site, standardized approach.

The World Mental Health Framework: WB

The World Bank (WB) and International Monetary Fund (IMF) are involved in mental health as well as other aspects of development work that require international assistance and funding. The WB, primary provider of loans for health services development in poor countries, has obvious interests in efficiency and monitoring of the programs it funds. Standards and guidelines, quality

assurance models, particular diagnostic categories and treatment protocols are of key interest in monitoring and evaluating plans set out by The WB. Clear guidelines, 'do's and don'ts', are detailed by The WB for how mental health services must be organized in order to qualify for loans. In WB guidelines the bank suggests: do create demand by promoting services, providing public education, do improve access to service, do ensure policy and budgets exist that maintain the priority of mental health services, do maintain standards and guidelines, do coordinate access to drugs, and do explore the role of alternative services (WB, 2000).

The guidelines are laid out in the interests of both monitoring the way funds are managed, but also in the case of mental health care, promoting broader productivity and economic development. In their "World Health Report" (2000) The WB reports that new research identifies that psychiatric disorders account for 11% of the 'global burden of disease'. This global burden particularly looks specifically at disability and loss of productivity in the labour and consumer market. Four out of ten of the top causes of disability are reportedly due to mental and neurological disorders; depression is particularly noted as increasing. Women and depression and the alarming loss of productivity in the work environment are noted in The WB reports. Costs of these disabilities of mental ill health and loss of productivity are noted in the high service utilization in hospitals and public health sector (WB, 2000).

The WB guidelines for mental health, "Mental Health at a Glance" (WB,

2000) make several recommendations for managing the loss of productivity and 'burden of disease'. The WB recommends the "development and implementation of standards and guidelines, strengthening of support and supervision of mental health care providers, and the support for development and implementation of mental health management information systems" (WB, 2000).

World Bank Guidelines and Standards

The WB directs its customers towards standards and guidelines in order for these debtors to comply with monitoring and evaluation procedures. The WB guidelines for monitoring and granting loans are clearly are in harmony with the guidelines of The WHO. Of particular interest are the notions of developing and implementing mental health management information systems. WHO guidelines, research strategies and tools have evolved through several years. Such tools as the Quality Assurance Handbook, and the ICD-10 Classification System can be seen as an example of official standards to which nations must adhere as they are reporting on and seeking loans. Documents that include checklists and glossaries have been designed through The WHO Division of Mental Health by select experts in the field of psychiatry to assist in the development of programs of quality assurance in mental health care. What WHO standards represent holds authority and are the standard by which the WB set criteria and holds customers accountable. In other words, financial assistance is to some extent dependent on debtors using the particular ideas of the WB and WHO in their policies and practices. Taking action for improving research and maintaining

clear strategies for diagnosis and treatment are two of the many ways quality assurance is checked and measured internationally to maintain accountability (Bertolote, 1994). The base of the tools and frameworks, as they are currently activated, are those studies that have been built on and reported in what is known in the international development community as the "Harvard Report" (Desjarlais et al, 1995). Desjarlais et al's (1995) text, "World Mental Health: Problems and Priorities in Low Income Countries", focuses on the 'Global Burden of Disease' perspective and the notion of disability adjusted measurements of productivity in their calls for action. It is the work of a key group of WHO researchers/directors, academics, and The WB Mental Health policy makers. The foundation of The WHO work of the ICD-10 is taken for granted as the common language of mental health internationally in the Desjarlais et al (1995) text. In my analysis of the discourses on 'Mental Health' I have found that the perspectives are not isolated but rather integrated and connected as a framework for which to develop and 'do' mental health. This weave of conceptualizations and recommendations in the discourses, I have come to call the 'World Mental Health" framework. Together the framework, a constellation of mental health conceptualizations of The WHO, The WB, and academic literature, incorporates the interests of all of these actors in international development.

International Development and Mental Health

In order to 'do' accountable mental health work, with the research, programmes, quality management measures and assorted other requirements,

there are associated financial costs to maintain quality programs and secure loans. WHO reported in their 1997 annual report that "in the United States of America alone, the yearly cost of depression is estimated at US $44 000 million, equal to the total cost of all cardiovascular diseases" (WHO, 1997, p7). These discursive accounts construct a case that, in order for poor countries to begin to tackle these issues 'properly', they must receive help from the international community. Desjarlais et al (1995) further the call for assistance, research, official aid and 'political will' to developing nation's mental health programs. In order for poor countries to 'do' mental health properly it is made clear that the international community must be involved.

The international development discourse has traditionally treated development as a 'top-down process" (Black, 1991, p20). This implies control of decision-making by major donors in centres of established power, and the overlay of technologies and ideologies of modernization from these centres to those less 'developed.' The assumption of trickle-down development (Black 1991, Webster 1990, Neufeld 1995, Leys 1996), of material benefit moving from those best positioned to the neediest is also articulated in the international development discourse. From this perspective, an overall enhanced productivity as the goal of the betterment of those fortunate enough to be able to stimulate the economy, and 'prime the pump' for further economic turns would be considered evidence of development in this perspective. The tendency was (and continues to be) to measure development in monetary terms with this notion of

'priming the pump' at the centre of development planning. The United Nations makes an index of development using this quantification of development by monitoring gross domestic product. Production in the UN determinants measures international development (of which The Gambia ranks '165th out of 175', UNDP, 1998).

The development thinking in the 1970s was that human rather than material resources should be the measure of progress. This led to great attention to employment and unemployment as key issues of development throughout the 1970's (Webster, 1990). Later, the 'bottom up' approach to development was designated in the 1980's and called for empowerment, attending to health and education and locally based problem solving. Expressing this more socially conscious approach, new measures for quality of life have became de rigueur (WHO 1998, Desjarlais et al 1995, Walt 1995).

Theorizing about development has evolved since the 1970s and successful development has come to represent something quite different than economic measurements. Critiques of 'modernization theory' and 'underdevelopment theory' have framed much of this analysis (Harrison and Huntington, 2000; Stackhouse, 2000). Some of these trends lead readers to consider how issues of 'cultures of poverty' are influencing international development (Harrison and Huntington, 2000). Other trends have us rethink how 'local' communities act and know development in ways that are both technologically appropriate and culturally/environmentally protective, ways that aid and foreign loan agents

largely ignore (Stackhouse, 2000). Further literature of the international development critique elaborates on the corruption of international organizations, aid agencies and local governments. Hancock, in his 1989 publication "The Lords of Poverty", states: "it seems to me to be beyond dispute that aid does not work" (Hancock, 1989, p190). In particular, new discursive trends in thinking about development issues and the "unsatisfactory progress of humankind towards prosperity and political pluralism" (Harrison and Huntington, 2000, pxxi)) have emerged from a group at The Harvard Academy Symposium. This group has refocused upon the role of cultural values and attitudes as either facilitating or constraining particular notions of progress.

An emphasis on enhancing 'progress prone' behaviours, strategies and attitudes and discouraging 'progress resistant' styles and approaches has evolved (Lindsay, 2000). While the discourse describes trends in somewhat different directions, practices in the field have maintained certain top down features. These general international relations and donor practices are represented in specific health programs including mental health.

Official aid, which I have come to understand as aid through the grants and loans of The IMF/WB (The International Monetary Fund and World Bank), has been theoretically the most effective means of 'stimulating development' and stimulating productivity and consumer activity through international relations (Neufeld, 1995). Those in oppressed nations are encouraged to borrow from institutions like the IMF/WB. This assistance is said to be preferred to

commercial banks or even philanthropic aid because (in theory):

> it can be used to develop social utilities, which might include schools hospitals and non-commercial establishments; it can be more carefully controlled by officials in the field to ensure funds are received by those it is intended for; it can be obtained by donors in various forms and terms and is considered more flexible a source than private sources and is usually cheaper because of grant offers or interest free-loans. (Neufeld, 1995)

Although loans from official sources have been provided at relatively low cost to oppressed nations, there is a very large debt burden that is a unique feature of the process of development as experienced by those countries being 'developed'. This has been attended by increasing hunger, illness and poverty. The literature is increasingly flooded with the sense that the current ways of working in development are not successful (Webster, 1990). The major international agencies distributing aid include the United Nations, the Organization for Economic Cooperation and Development (OECD) the International Monetary Fund, European Union, and various agencies of The US Agency for International Development. My experience in The Gambia demonstrated these discourses at work, as I worked in a health service almost totally funded through loans from the WB, aid agencies and philanthropic institutions. This lending is, of course, at the price of interest payments and 'the interests' of the lender regarding how loaned funds are used.

Western aid programs are selective in that most support those countries which are friendly to Western interests of the free market, and Western ideals of modernization and progress (Neufeld, 1995). This is referred to as aid tying in

the international development discourses (CIDA, 2001). This practice has tied official aid to the purchase of products and standards of the donor. Regarding economic measures however, developing countries may pay an average of 15 to 30 percent more for goods and services under tied-aid requirements; in Canadian foreign aid food loans 90 percent of the loan is tied back to the purchase of Canadian goods (CIDA, 2001). Health care focused loans would similarly be tied to the goods and services of the donor county's medical/pharmaceutical goods and services. The costs to poor nations are great and reach beyond those of economic measures.

Loans and the 'Common Language' of Basic Need

The concept of "Basic Need" is woven into the discourses of the 'World Mental Health Framework' and research, programs and development. Mental health services and research directions are described as 'inclusive' of the basic needs, or needs that are considered universal and have priority for development. Some of these directions are illustrated in the development and mental health discourses as: governance and peace in conflict, improving multi-lateral effectiveness (CIDA, 2001) and other supposed routes to political safety, productivity and enriched economies.

Western interests, economic measures and modernization have come to be represented in the 'common language' and discourses in international relations and development work. One of these dominant discourses is the 'Basic Need' discourse represented in international lending and aid criteria. This

discourse suggests that attending to basic human needs is the route to development and "the only genuine way in which economic growth will occur in the Third World" (van der Hoeven, 1988). The basic needs of the population are considered common and universal in this literature. They have come to represent the interests of donors (like the WB) that have become pre-occupied with aid towards economic reform and political stabilization in the name of meeting 'basic needs.'

Mental health frameworks have connected with the 'inclusive', basic need discourses over the last several years, so the Desjaralis et al text (1995) asserts. The definitive 'call for action' has been set out and suggests that, while great strides have been made in developing mental health services and research, new technologies, methodologies and treatments must be adapted for use in diverse cultural settings. These actions, it is said, must be 'inclusive' and cross the circumstances of poverty, violence, displacement and other health problems that connect to 'World Mental Health' (Desjarlais et al, 1995). Issues of international development and mental health are woven together by the discourses of the WB and WHO in name of sustaining basic needs and economic development, the recent language of loaning.

Tools for Development: World Mental Health and The WB, WHO, and WFMH

In July 2001 The World Assembly for Mental Health was organized by the WFMH (World Federation for Mental Health), an organization with official advising abilities with the United Nations. At this event, collaborators in 'World

Mental Health' converged and the framework was made visible to me. The framework that ties The WHO, WB and WFMH together to understand and promote action for mental health services became a social fact, or common sense. A 'World Mental Health' framework existed as 'fact' at the 2001 Mental Health Congress with speakers from each sector present (health, banking, international development, academia, bio-technologies, and other corporations like publishers) and using its language, speaking from shared assumptions that I have described previously in this chapter, and working to activate the framework discursively. The work of advancing the 'World Mental Health' discourse is done at conferences such as this. Activating the framework allowed those in attendance to hear research from the health sector crossing over into the talk of the World Bank and visa versa. It is of note that the crossover of these sectors (particularly the bio-technology and pharmaceutical industry influences in the 'World Mental Health' framework) was heavily protested by consumer/user groups and anti-globalization activists. Overall the "Burden of Disease" and economic discourses of The World Bank weighed heavily on the discussions at this international conference. Especially singled out for critique by mental health service users was the view of aid being allocated by "Burden of Disease" and the WB's involvement in mental health funding (Mad Pride, 2001).

In his opening address, Dr. Marten DeVries from the World Federation for Mental Health called for mental health services to "reorient ourselves to the new epidemiological and cost factors of mental health services". He spoke of a

"science of sustainability" towards which he felt mental health services should re-orient. Within his address the discourses of classification of disease, productivity, 'Global Burden of Disease' and DALYs were clear. Similarly, Dr. P.H. Barret, president of the Canadian Medical Association, also spoke of the statistics of the 'Burden of Disease', ever-increasing magnitude of the problems of mental ill health and economic burdens that correspond. He spoke to the important role of physicians, calling for increased 'standards', consensus on strategies and the development of research capacity.

Dr. Ahmed Abdou El Azayam, the World Federation for Mental Health (WFMH) President, spoke of the 'two way relationship' of The UN/WHO and non-governmental organizations. He highlighted the importance of fostering a science base, improving standards and monitoring in legislation, policy and diagnosis and treatment. He called for the establishment of clear protocols for the management of psychiatric disorders, quantifiable diagnostic measurements and corresponding drug treatment protocols.

Florence Babgaba, Mental Health Specialist with the World Bank in Public Policy and Mental Health spoke on the WB perspective. In her speech Babgaba did not try to conceal the WB's mandate, but spoke about it as "a lending institute, whose partners are client countries and whose mission is to alleviate poverty". Babgaba reported progress of The WB in these regards. Studies looking at cost effectiveness of psychosocial interventions were referred to as the "productivity of the WB". Production of a mental health fact sheet, and

numerous meetings in the vein of social capital and mental health and mental health financing were described. These fact sheets address plans of The WB for measuring disability, mental health and work. Her concluding remarks were words of advice about the importance of monitoring and evaluation (addressing 'input, process and output'). She spoke of the need for evidence of effective (and specifically 'cost effective') interventions that are applicable to developing countries. Babgaba suggests interventions "can reverse the dysfunction thus leading to increased productivity and economic development".

Dr. Rachel Jenkins (Psychiatrist with The WHO Collaborating Centre in London) spoke about getting mental health into public policy. She cautioned that DALYs do not include 'everything' and suggested that country-to-country the situations are very different, and although similar issues do exist, locally tailored solutions are important. Yet her views are contradictory. She also stated that there needs to be increased access to an international evidence base, specifically recommending epidemiological methods. Jenkins also noted that The WHO had lobbied for developing countries to have internet access to professional medical journals (Wall Street Journal, 2001). Professional journals are another vehicle the distribution of knowledge. Making dominant Western knowledge available at a fingertip further reinforces a particular kind of knowledge development internationally, again in contradiction to locally tailored knowledge development. Also in contradiction to the locally tailored approaches she lauds, Dr. Jenkins and The WHO report on the importance of integration via training and guidelines,

specifically the ICD-10, and corresponding essential prescribing. Global responses and interpretive frames (Western, scientific, psychiatric, and pharmacological in orientation) were promoted throughout the World Assembly for Mental Health. The 'World Mental Health' was visible, but taken for granted as 'fact' and a benefit throughout the event. I was able to see the largely unquestioned dominance of the framework and how I, as a practitioner and development worker, enter into the discourses.

Mental Health and Development To Enhance Productivity

The WHO, WB and WFMH representatives all illustrated their entering into the discourses of 'World Mental Health'. In the World Mental Health Assembly, representatives repeated the message that mental health development and progress are accomplished, among other ways, through highly standardized research programs, numerous special "mental health days" and other quality management tasks. The ever-increasing numbers of nations complying and organizing within the targets and frameworks set out by the WHO, WB and WFMH also demonstrate an advance to mental health according to these experts. In these messages, it can be seen that mental health development is strongly linked to international development through the 'World Mental Health' framework. In the framework, mental health problems are named as burdens to productivity and capitalist society. Standardized treatments and research for these burdens to productivity are strongly encouraged.

An interesting aspect of the conceptualizations and methods for

implementation of the global view of mental health is that these concepts are part of an organizational framework. This is a framework that manages and surveys the use of resources throughout the world; it is, in Smith's (1990) terms, a 'ruling organization'. I saw the interconnection of the research agendas, themes and discourses at the World Mental Health Assembly. The social relations involved in mental health research are indeed complex and organized but also highly invisible because in Western terms they are assumed the most appropriate and common 'fact'. The discourses on 'World Mental Health' and 'Development' make visible some of the assumptions, dominance and complexity of Western economic and scientific discourses. The discourses of 'World Mental Health' have a programmatic sequencing of actions that works actively with and through local practices as analysis attempts to make visible.

Chapter Three

"Methodology: Out of the Discourses And Into Something More Comfortable"

I have conducted this inquiry as institutional ethnography, drawing on Dorothy Smith's writings (1987, 1990a, 1990b, 1999), and my studies with Marie Campbell, publications and conference presentations by Smith, Campbell, and others who use institutional ethnography (Diamond, 1992, Ng, 1996, Mueller, 1995, McCoy, 1995). This chapter discusses briefly the most important and relevant concepts upon which institutional ethnography relies in addressing the problematic of everyday life. Pointing a direction for my later analysis are central concepts of experience and knowing the everyday world, social relations, ruling practice, and texts as elements of social organization. In this chapter, I also describe my standpoint and note how I collected data for my inquiry. I explain how I used that data in the two areas of analysis I report on in the next chapters.

Theoretical Underpinnings: The Social Organization of Knowledge

The theory that guides my thinking is Smith's "social organization of knowledge" (Smith, 1987, 1990 a and b, 1999). This is a feminist-inspired approach to knowing and understanding social life. Feminists learned in the women's movement that their experiences might be different than official versions and/or their experiences as women might be entirely overlooked in the making of official accounts. Women can be excluded, subordinated and left

outside the realms of power. Women scholars began to review the ways that women's lives were thereby disadvantaged. Smith's scholarship as a critique of the official practices of scholarly knowing that excluded women. She went on from there to propose a new sociology, one that 'explicated' women's experience - or showed how it was organized as it was.

Experience and Knowing the Everyday World

Of course, not just women are outside the places where power is exercised. Developing countries are in a parallel situation to that of women in a male-dominated world. Added to their exclusion from being creators of the rules that run their lives, people in developing countries suffer from economic deprivation. The Gambia had no tax base and was thereby dependent on international aid that has with it other ties and accountability structures. There is actual work going on in the name of 'development' and the process of understanding that development work asks that we make sense of it in a particular, materialist way.

Institutional ethnography examines the 'matter' and 'matters' of the setting. My ethnographic data - my observations, interviews, photographs and notes of my experiences in the setting are important to my analysis, but are not the only data upon which I rely for analysis. Rather, I 'explicate' that data; I show how it is organized in "a world of time and activity and materiality" (Smith, 1987, p122). I am looking for how experiences and experiential accounts are organized. I am looking for the material happenings of the everyday world of

mental health research and care; my experiences *as they are organized* are data. Smith's social organization of knowledge allows researchers to make such material connections. 'Theorizing' how everyday life is organized however, is not sufficient in institutional ethnographic research. Institutional ethnography is an inquiry into the material actualities of the specific social organization of the setting; the methodology seeks to "explicate rather than explain" these material actualities (Smith, 1987, p126). In my research, asking how my experience in The Gambia was organized is a useful question. What happened to me was organized somehow and with Smith's approach, this organization can be explicated. My analysis offers insight into 'social organization' – such that what actually happened, as I have described it, can be understood.

Social Relations and Ruling Practices

All research works to 'make sense', but different approaches make sense of different things in different ways. Central to the institutional ethnography approach is the concept of social relations. I wanted to see the social relations in the social organization, which I (and other people) am an actor in. The underlying belief about social reality in institutional ethnography is that people enact social life and thus a social inquiry must be framed in such a way as to capture accounts of what people do. (Campbell & Gregor, forthcoming). The analytic attention that the researcher brings to her data is to discover how people's actions, lives, and experiences are socially organized. Smith's (1987) concept of social relations is central to such an inquiry. People are assumed to

be acting knowledgeably as they conduct their lives. They know its local sense but, as a researcher, it is my goal to explicate how their actions are socially organized and put together to result in what is observed, told about and so on. My explication draws what is missing in the people's stories, or my data, in the account being made. In the social relations of the setting there appear clues and I follow these outwards to where they originate to understand the social relations organizing the setting. My explication is a drawing in of the otherwise missing social relations that come to organize everyday life as ruling practices; it is metaphorically finding the missing piece of the puzzle.

One begins this explication of the puzzle, Smith says, with the experiences of those with whom one takes a stand, and explores how their experiences are organized as they are. My inquiry is about my own experiences as a mental health worker in The Gambia. I have a standpoint in relation to the framework I have described in Chapter Two, one that puts me in a social relation with the discourses of development and world mental health. I am there as one being organized by the conglomerate of international actors who, through ruling practices, construct a standpoint I call the 'World Mental Health' framework. Smith states, "a standpoint in the everyday world is the fundamental grounding of modes of knowing developed in a ruling apparatus" (Smith, 1987, p108). Ruling relations in my mental health work exist through the apparatuses of the 'World Mental Health' framework. The apparatus and technologies of the 'World Mental Health' framework include the rules/systems of funding, official terms and

categories and research templates yet are not in and of themselves ruling practices. Ruling can only exist as part of a ruling relation, practiced in actual people's everyday work.

My 'problematic', as explained in Chapter One, is about knowing my work in two different ways: knowing my work both experientially in my everyday work as I have narrated for you, and also officially through the 'World Mental Health' framework. This bifurcation of consciousness (Smith, 1987, p84) was uneasy for me personally, a somewhat naïve, but well-intentioned development worker.

Experience as Data

To conduct an inquiry into my own experiences I needed to generate some data for analysis in addition to conceptualizing the study. Certainly, I used my own memories of my work in The Gambia as the basis for the development of the problematic. My work as a technical advisor offered me the opportunity to gain a familiarity with the setting in which my research is set. I was immersed in the mental health work that I did in The Gambia. I needed no further observations to arrive at a puzzle that needed explication. As Campbell (1998) suggests, these experiences were the 'entry' to understanding how my everyday world of work in The Gambia was organized. Some of my accounts of that work were aided by my journal, which I kept routinely as a method of accounting for my practice. I also relied on my photographs and slides that documented my experiences and how the CMHT worked. Additionally, I reflected on letters I had sent to friends, family and colleagues back home. These letters became a sort of

journal I shared and many of my friends collected them and gave them back to me upon my return. These are sources of the experiential data that provide the informal knowing, the knowledge of the everyday, that I have set down in several chapters of this thesis. My experiential involvement with co-workers and patients in The Gambia was an important base of knowing the standpoint of everyday mental health work in The Gambia.

Texts as Elements of Social Organization

Arrayed against those accounts are my experiences of being involved in a research project in The Gambia. I have explained already how and why I undertook the 'The Pathways Study'. More documentation was demanded of the CMHT in order to get recognised 'officially' and to receive a place in the longer term planning for mental health care through international loans. My inquiry focuses on the documentation and study we undertook as a socially organized production of knowledge that was generated 'scientifically' to replace the more informal accounts to fit neatly into the 'World Mental Health' framework. Data for this analysis include the 'Pathways Study' documents, the actual survey instruments, including several of the completed questionnaires, as well as the books, papers and articles about 'The Pathways Study's' findings elsewhere, and the research on mental illness in developing countries from which it originated. My analysis is of this collection of data.

Analysis: "Activating the Text" and "The Text-Reader Conversation"

My analysis began to make clear how the CMHT's and my own standpoint

began to be organized as it was. In my analysis I demonstrate how 'The Pathways Study' I implemented is a set of texts organizing our standpoint. As my team and I implemented 'The Pathways Study', we participated in the social relations of which it is a part. My analysis of the work we did in The Gambia with 'The Pathways Study' explicates its involvement with the relations of ruling in 'World Mental Health' and 'Development'. I take up that analysis in the next two chapters as I investigate both the "activation of text" (Smith, 1990b) and "the text reader conversation" (Smith 1999).

Smith has drawn our attention to how texts work to carry social organization across the boundaries of settings and how these relations can be studied in the analysis of texts' meanings and courses of action. For Smith, "texts speak in the absence of speakers" (Smith, 1990b, p211). In Chapter Four I investigate the ethnographic data of routine patient assessments with and without the aid of 'The Pathways Study's' 'Encounter Form', or survey instrument. I explicate how the text stands in and speak for us as practitioners in a patient's routine assessment. As we encountered patients we activated the text of The Pathways survey to assess them. In the analysis I describe the 'Encounter Form' to make sense of how we 'encountered' our patients through the form. The analysis guides my recognition of the privileging of certain (dominant Western) pathways to mental health care over than (local) others. As texts are taken up into actions they enter a weave of social relations (Smith, 1990). This analysis draws out the different social relations, more specifically a ruling relationship,

that the text brings those who activate it into.

A "text-reader conversation" (Smith, 1999) is another analytic technique used in institutional ethnography research to explicate relations of ruling. This is an approach to analyzing texts that comes from Smith's (1999) engagement with Russian language theorists, such as Bakhtin (1981) and Volosinov (1983). In my work with the "text-reader conversation" I draw on Liza McCoy's (1995) explanation of her analysis of photographic texts. Drawing on Volosinov (1983), she points out that a "text comes to 'mean' when a person involved in everyday ways of making sense "draws the work into some particular social situation" (McCoy, 1995, p181). She speaks of the recursive features of text in use as organizing and claims:

> This drawing-in establishes relations between local circumstances and relevancies and the material resources of the (text). Although each drawing-in is historically unique, it occurs within courses of action that organize the interpretive practices available to the (readers). (McCoy, 1995, p181)

The 'text-reader conversation' thus uses the resources of the text in a particular way to understand how texts are 'intended' to be read by those who construct them. Words and symbols from the text cannot be employed to suit the purposes of the person making the interpretation, but rather must be discovered to have meaning in local situations of use that draw on extra-local textual resources. The textual resources I rely on lead me to background documents of 'The Pathways Study' whose meanings are drawn into the local setting.

In order to take up the text-reader conversation I focused on the material

resources of the 'Development' and 'World Mental Health' discourses, as discussed in Chapter Two. These discursive frameworks, along with the structure of the survey instrument we implemented (an 'Encounter Form'), it's antecedent documents and studies profiling "The Pathways Study' all draw meaning into the reading and uses, the social relations of 'The Pathways Study' text. The conversation as part of a social relation has words, symbols, and other clues to the origins of elements of the text in discourses outside of the local setting. In my review of the discourses on 'mental health' and 'development', clues in references to 'Burden of Disease' are frequently cited in WHO literature (WHO, 2001). These clues refer the reader back to the discursive origins of the WB's measures of Disability Adjusted Life Years and economic burdens/loss of productivity. I was implicated in those social relations in my work in The Gambia, and this is necessarily so in the socially organized world.

Smith's "social ontology" of institutional ethnography is not an objectifying method (Campbell & Gregor, forthcoming). I do not attempt to stand apart from what I research or to construct my inquiry in objective terms. Rather the topic is explored, from a standpoint, as I know it, from inside my mental health work in The Gambia. I was part of the social relations of ruling being put in place as part of the 'development' of mental health treatment in this country. Working with 'The Pathways Study', I advanced development work, as my analysis in Chapter Four and Five makes clear.

I show, promoted a more 'professional' approach and importantly, it further embedded western psychiatric diagnoses and pharmacological treatment into our work as appropriate' and efficient treatment. I also argue that it begins to translate local knowledge and practices into concepts such as 'delays' that have special meanings within the 'World Mental Health' framework.

In discussing the findings of my analysis of 'The Pathways Study', I recognized the contradictions that emerge. I was part of the development work being done in The Gambia that was importing Western methods to bear on local practices. Yet, I saw that in addition to the benefits occurring, there were losses. As relations of ruling, 'The Pathways Study' was one means of subordinating local practices to the dominant 'World Mental Health' framework.

Pathways and Studies of Social Relations

As noted in Chapter One, I was part of a study that was established on the encouragement of the local health authorities, the Gambian WHO office, and aided by financial support of the Canadian Bureau for International Education. With the support and the commitment of our mental health team we were able to get a study together that these international actors in health and development would hopefully be interested in and listen to as legitimate in our pursuit of sustainable funding.

In my search for continuing financial support for the CMHT project I kept running up against the demand for better information. I was directed by the advisors at the national WHO office to the various WHO resources available

Chapter Four

"The Pathways Study Construct of Meaning: Thinking Globally and Acting Locally"

What is the effect of thinking globally and acting locally? As I felt the disjuncture I described in Chapter One, and puzzled over issues of the sustainability of my program, I wondered what part I was playing in the development of health services. In this chapter I show how a small 'self-study' I conducted focusing on how patients sought help can be seen as part of what Smith calls 'ruling practice'. Indeed, I came to see how in implementing this particular 'Pathways' study on mental health services, my colleagues and I transformed local accounts of people's troubles, problems, worries and pain into a language of psychiatry that make it actionable using methods determined to be correct according to extra-local standards.

In this chapter, I analyze the way 'The Pathways Study' works to build a specific kind of understanding of mental health care in The Gambia. Embedded in the 'World Mental Health' framework are specific notions of causation and approaches to help and treatment to which this analysis points. In the next part of the analysis, I argue that doing 'The Pathways Study' was itself 'transformative' of the mental health work that my colleagues and I in the CMHT conducted with the people who sought help from us. Of course, I had been working to 'develop' my colleagues' knowledge and skills and we had been seeing more patients and making contact with more local healers. The study, as

(statistical assistance and reference materials) to assist us in understanding how to develop CMHT services and document our activities. Quality assurance guidelines, research and statistical studies specifically targeted for mental health were ordered by the reference librarian for our purposes in the second year of my tenure as a volunteer. The study I selected to gather statistics, alongside our usual recording system, was based on the Pathways to Care Study (WHO, 1981). The program manual for 'The Pathways Study' comes from the Mental Health Division of The WHO. We obtained these documents through the support of the WHO's national office in the capital city of The Gambia. The survey we used was part of a larger cross-cultural program of research adapted from the formal 'Pathways Study'. The larger program manual of studies initiated by Gater et al (1991)

is intended:

> to allow mental illness services to develop; to prepare the ground for intervention studies; to form a research basis for the development of new training courses for staff; and to identify mental illness tasks, which can be carried out by primary care physicians, nurses, native healers and mental health aides in order to help the mentally ill and their families. (WHO, MNH/NAT/87.1).

Description of The Encounter Form

'The Pathways Study' instrument consists of several printed pages of questions that are called 'The Encounter Form'. The form, its description, instructions and my observations of how the interview is conducted are data for the analysis that follows.

The first page of the form locates the 'source' of the instrument in the top left corner. This identification is "MNH/NAT/87.1 Page 1S". To the right and at the top of the first page is the identification "Annex 1." After these identification headers, the title at the top and centre of the form is "'The Pathways Study': ENCOUNTER FORM". Then several lines of instructions appear to the interviewer to guide the interview for what the survey calls an 'encounter', with a patient. The instructions asks that the health worker carry out their:

> usual full clinical assessment, with particular attention to the sequence in which symptoms were developed. There will often be only one referral between home and mental illness services, in which case only section 1, 2 and 3 would be completed. (WHO,)

The title of the first section of the first page is '1. BASIC INFORMATION'. 'Basic information' then lists questions with a line after each question where the interviewer can write in the response. To the far right after each question and the space for the written information is a small box, which is followed by numbers that are listed in ascending order.

The specific questions in 'Basic Information' are: the name of the facility at which the patient was seen, who filled in the form, on what date, the patient's initials, the date the patient was first seen by mental health services, the date when first symptoms developed, how long ago symptoms developed and the diagnosis (then translated into ICD-10). One example (below) reports on a patient who expressed some disturbance in thinking. The italicized words (below) are information an interviewer added. The 'Basic Information' questions

looks like:

1. BASIC INFORMATION

1.1) Name of facility at which the form is filled in: *CHMT Office*

1.2) Form filled in by: *MA*

1.3) Date: *31 May 1999*

1.4) Patient's Initial: *XX*

1.5) Date first seen by mental health service: *31 May 1999*

1.a What was first symptom developed by the patient?: *Isolative, loss of appetite*

1.b) How long ago? (number of months): *3 years*

1.c) State diagnosis: *Schizophrenia* – ICD-10

The next page of the 'Pathways Encounter' form has the title " 2. THE DECISION TO FIRST SEEK HELP" at the top left hand side of the page. Beneath the title are further questions with spaces for a written response or checklist of possible responses (see over). After each response or checklist are a box and a number after it. For example, on the next page, (with the interviewer's information italicized):

2. THE DECISION TO FIRST SEEK HELP	
2.a Who was first seen?	0=native/religious healer practitioner 1=police 2=social worker 3=community nurse 4=osteopath 5=medical 6=general hospital 7=psychiatric services 8=not known
2.b How long ago (number of months):	*48 months ago*
2.c Who initiated first contact?	0=patient himself/herself 1=relatives/friends 2=neighbours 3=workmates/colleagues 4=employer 5=police 6=medical practitioner 7=other (specify) 8=not known
2.d What symptoms caused decision to seek care? (specify):	*sleepless night, irritability, excessive fear of being bewitched, social withdrawal.*
2.e) What treatment(s) was offered?:	*local treatment, herbal to bath/ drink, juju to use.*

Pages 3, 4, and 5 of 'The Encounter Form' offer spaces to document 'a referral'. These note the referral from the previous practitioner, recorded as seen on page 2. For example, the title of the third page is "3. THE FIRST REFERRAL", the title of the fourth page is "THE SECOND REFERRAL", and so on,

for example:

Who was next seen?	0=native/religious healer 1=police 2=social worker 3=community nurse 4=osteopath 5=medical practitioner 6=general hospital 7=psychiatric services 8=not known
b) How long ago? (number of months)	*One*
c) Decision taken by whom?	0=patient himself/herself 1=relatives/friends 2=neighbours 3=workmates/colleagues 4=employer 5=police 6=medical practitioner 7=other (specify) 8=not known
d) What symptoms caused decision to seek referral <first second or third> (specify)?:	*sleepless night, not responding to treatment, social withdrawal*
e) What treatment(s) was offered?	*Tryptizol 75mg nocte, psychotherapy*

This would be repeated for any other referrals described by the patient.

'Routine' Assessment and The New Knowledge: Implementing the Survey

Through 'The Pathways Study', we heard stories and translated them in a specific way so that the administrative authorities would know how to understand the patterns of patients' pathways to accessing mental health care.

Correct reporting and reading was where we were directed in our path to secure sustainable funding. Being able to categorize and report on our practice in terms understandable in the administrative arenas of primary donors (The WHO and WB) was clearly becoming an important feature of our work. How we heard the patients' stories and translated them is of interest in understanding how my experience and disjuncture came to be organized as it did. To look at how this process happened, I explore the translation by our CMHT of local stories and needs into the terms of 'psychiatry' that correspond with 'appropriate' treatment categories. We conducted the survey by having CMHT nurses ask the questions on the survey to patients as part of the 'routine clinical assessment', as is advised in the WHO research template for the study.

Routine Clinical Assessment

An actual everyday routine clinical assessment with the CMHT could be described as anything but routine. Every day would vary significantly based on whether we were in an urban or more rural health centre, whether we had adequate fuel to meet our destinations, and whether the announcements that we were coming to those more remote areas had reached the intended community, offered by radio or village voice. If so, we would likely be met by colleagues and patients in our journey. If our arrival hadn't been announced, often we would have to find a 'tour guide' who knew the geography of the less accessible regions and could point out where patients (new users or patient's receiving follow-up care) had been identified in the villages.

These journeys to provide 'routine clinical assessment' were quarterly events. Although they were anything but routine, a typical illustration of the 'trekking' day would include: the CMHT, comprised of two CMHT nurses (usually one of the national staff along with myself), a nursing assistant, and a driver, leaving the home base of the psychiatric unit in the capital, Banjul. We would typically bring along another nurse colleague returning from holidays and needing to be dropped off along the way at a health centre, in order to return to work. We traveled into the more sparsely populated rural areas, in our canopied truck, for a long trip of over three hundred kilometres. The main roads were paved but roads off the highway into the health centres or villages were unpaved and often in poor repair. We frequently blew tires on these journeys, at times waiting an extra day or so to attend to this problem. Every sixty kilometres or so, we would encounter people we already had registered as patients. Others were brought to us where we set up 'clinics' at small health centres along the way. Occasionally relatives would bring a patient to us whom they still had shackled or chained as a form of restraint. Sometimes the queue at such a clinic would be hundreds of people long; people would wait outside seeking the shade of trees. Still others we would see along these stops at the local healer's (marabout's) compounds. Our method of work was informal. We would visit in people's homes or we would work at tables set up outdoors under a gazebo structure at the small health centres. Occasionally we would just meet a patient at the riverside, roadside or in a store to follow-up or make a first assessment.

As in all interactions in The Gambia the importance of greetings, and a ritual of questions/answers and blessings/prayer would be exchanged at the outset of any conversation or interview with patient, family or health centre staff. Living in the small country of The Gambia, the CMHT nurses would often have extended family relations or know of patients through these sorts of community connections. We talked to people, our patients with mental illnesses, their family members and friends, to village leaders and rural health workers. We made personal and individual connections in this 'routine assessment'. Our interviews were at times brief, the queues were long and the days extraordinarily hot/humid. Our interactions were often filled with laughter as the news of the village and stories of the people and families we were 'routinely' assessing were shared.

It was rare we would see a patient alone. Typically at least one family member accompanied the patient to our clinics or we might have an entire family around if we were at a home visit. We also made visits to local healers, shared perspectives and treatment strategies with the marabouts, and provided support to one another in our distinct practices. When we consulted or interviewed patients in the marabouts' compounds it was also common to have at least one other family member present. Sometimes we would eat lunch or take water if food/drink was offered (as is common local practice and communal dining is the norm) at the compounds of the healers or families.

The local healer's distinct practise helped me to see more of how local

beliefs were practiced. Often the local interpretation of the cause of a disorder would be centred on personal/social distress or connected to what people referred to as 'curses'. Often they would have approached local healers for charms, prayers or spiritual healing given the difficulties manifesting from these 'curses'. These charms were called 'jujus'. As we worked as a CMHT the notion of causation was not something we argued, rather we spoke to and promoted treatment for the symptoms manifesting in these broad categories we described by symptoms as disorders of 'thinking, mood or substance use'. Over time we increasingly began more and more to name these broad categories of disorders differently in our public education and treatment work. Later we began to be more specific as we named diagnostic categories in public information or family teaching. For example, we would name certain thought disorders "schizophrenia". Even though large numbers of the population did not speak English, we began to utilize translations into Western psychiatric nomenclature as we expanded the awareness and education aspects of our work in order to have communities better understand 'mental health' issues. We were cautious of this practice, however limited this psychiatric language use was, designing many of our educational materials in drawings and Arabic print for local healers and health workers.

Our assessments were 'routinely' conducted in the course of such visual, local, personal and informal processes even while we began to integrate the more scientific terminology into our work. When the CMHT and our outpatient

department colleagues were implementing 'The Pathways Study' we further varied our procedures as follows.

Routine Clinical Assessment and the Survey Questionnaire

When conducting 'The Pathways Study', the CMHT oriented interactions with patients to the questionnaire. That is, conducting the survey changed our clinical practice. We attempted to interview people in order to get answers to the questions in the survey. Of course, we paid attention, as always, to what people wanted to tell us. We had become accustomed to 'interpreting' people's concerns and reorganizing these issues into themes of disturbances of thought, mood, anxiety or substance use. Now, through the survey, symptoms directed us to the formulation of a diagnosis and this diagnosis became important to the assessment and treatment. With a stronger emphasis on diagnosis came a stronger connection to a preferred and 'correct' treatment.

The CMHT nurses had been educated in the English language but in addition spoke several indigenous languages (most commonly Wolof, Mandinka, Fulla, or Seroulie) of which I only managed to grapple with very basic greetings and phrases. When conducting the interviews for 'The Pathways Study' the CMHT nurses spoke local languages with the patients and would translate and write in the 'Encounter Form' in the English language. I noticed that my colleagues with the CMHT enjoyed their work with the survey. Just as it is suggested in the research program instructions, it was a very simple survey to implement. Doing the record keeping in the official Encounter Form took on an

aura of professionalism for the CMHT. We also found the survey facilitated our interview work with a certain efficiency. The interview structure of the form structured our discussions with clients and eliminated some of the conversation and informal assessment that would happen in the form of less directed conversation. On a few occasions the transformed and efficient approach particularly struck me as I heard one of the CMHT nurses interviewing patients shouting "Next!" to call the next patient to his care. I began to see in that moment how such approaches got imported alongside the other so-called 'best practices'.

When we worked with 'The Pathways Study', not only translation, but also the questionnaire's structure itself altered the exchange of information and understanding of 'mental health', diagnoses, paths, and treatment. We would know and interpret the symptoms with psychiatric and Western medical notions of causation and treatment in mind. For example, when we heard from a patient with a range of symptoms and concerns; we would formulate a diagnosis and translate this into the ICD-10 categories. I began to specifically notice how we translated people's stories of complex societal expectations and suffering into what was categorized as "depression." On one 'Encounter Form' documenting a patient visit to a psychiatric clinic, first symptoms are described as "meditates a lot, withdrawn, thinking too much (not able to bear children)". These symptoms persisted over some time; the patient sought mental health care, firstly from a local healer. Several months after concluding treatment with a local healer,

symptoms worsened to include tearfulness, insomnia and loss of appetite and, on the advice of family, the patient came to our service where a diagnosis of "depression" was assigned and medical treatment prescribed. Typically once we made such a translation, we would then know that a particular diagnosis would benefit from a particular sort of treatment approach. Whether or not that treatment approach would actually be available at the time would vary depending upon supplies of medications (mostly purchased or donated through the WHO essential drug supplies) available. This lack of medication supplies did not detract from our team's understanding that we 'should' have particular remedies available to 'best' treat the diagnosis we assigned. We knew from the several years of experience that medications were often in short supply. This survey was actually one way to demonstrate that, given the categories and diagnoses, we 'should' be providing certain treatments, and needed these supplies. In many ways the change in our practice, and ways in which the survey transformed our work were being enforced by the requested documentation for official aid requests. We were repeatedly requested to construct these formal reports on our work, in spite of the fact we did not have secretarial assistance or even stationary supplies available on an ongoing basis. One of the motivations we had for doing the study had been to support requests for additional medical supplies and support staff. By changing our practice we could potentially make this happen. In the short term, having a research study did offer immediate funds to cover fuel costs and travel expenses that were otherwise not always available for

our services. As we documented this information we hoped that, in the future, we could make a clearer case for our resource needs, medications, fuel and supplies. While we worked to complete this documentation to articulate our needs in institutionally acceptable language, we would take the locally observed incident, already worked up through the trained mental health nurse's questions, and translate the symptoms (however they may be viewed as caused) and apply a diagnosis. In doing so, we would as in the previous example, translate suffering into "depression", a condition to be treated. Following 'diagnosis', treatment strategies could be, and were, recommended by the CMHT.

Psychiatry and its Language: 'Appropriate Care'

'The Pathway Study' assisted our record keeping of not only how people accessed care and from who they sought care, but also the symptoms with which they presented, what their diagnoses were and correspondingly what treatments were to be given. Embedded in this question about diagnosis and treatment are assumptions, originating at the WHO Mental Health Division, about disease causation, symptom manifestation, diagnosis and appropriate mental health intervention. I point to the abstraction and translation process of ICD-10 that I argue is part of the ideological and organization practice of 'World Mental Health'.

The classification of diseases template, the ICD-10, with corresponding treatment protocols (in Canada, it is called the Classification of Interventions) is a subtext to 'The Pathway Study' and most of the international mental health research/program frameworks. The ICD-10 is fast becoming the world standard

for classification of mental illness, and is part of the 'common language' of the 'World Mental Health' framework. Based on the ICD-10 are new products and services for training and management purposes. A framework for implementing mental health services using ICD-10 language makes a bureaucratic accounting system possible. The management and monitoring of mental health and development is done through The WHO and WB; these institutions require a set of standards and common language that links back to local practice. These standards demand being orientated and trained in the 'World Mental Health' discourse that lives outside of The Gambia (though is increasingly woven into the fabric of national understandings and practices). The monitoring and evaluation standards also reside in pharmaceutical houses manufacturing the 'appropriate treatments' far from sustainable outside of the international financial institute of The WB. While clearly in need of extra-local, and pharmaceutical supports, the local healers and health centres were attending to people's troubles. Their involvement was different from 'mental health' treatment and in some ways it was more broadly based. Some of them distributed food to needy people through programs funded by The Gambian government. I had reason to suspect that our reports and this survey would make the local healer's work appear less worthy of support, as it increased the status of psychiatric treatment. These were some of the contradictions we faced as we implemented 'The Pathways' survey.

Chapter Five

"Textual Analysis of The Study: The construction of 'delays' "

The Pathways Study as a Measure of Delays for 'World Mental Health'

The World Bank and a specific Mental Health Policy Department closely monitor the financing of mental health services within the 'World Mental Health' framework therein. The World Bank's 'do's and don'ts' are clear in the discourse of 'World Mental Health' as shown in Chapter Two. For instance, in 'The Pathways Study' information is intended for government purposes of planning, like for the Five Year Health Action Plan in The Gambia, to obtain training opportunities from WHO, or to establish aid from international funding/lending bodies. Any such aid would typically be tied to certain purchases, and dependant upon measuring the numbers of patients to be served, their need for medication, etcetera. Once funded by external donors, methods of evaluation would be applied. For this kind of management of aid, a common language that translates local troubles into appropriate psychiatric treatment is needed. It is this discursive feature of the management of mental health aid that this chapter problematizes.

This chapter describes how the textual construction of the notion of 'delays' arises from the 'mental health' and 'development' discourses, is worked into the tools of the "World Mental Health' framework (namely 'The Pathways Study') and orients the reader of the 'Pathways Study' text into a shared or common understanding of how to hasten the 'correct' referral/treatment pathway

for patients. I suggest that the contradictions within the organization and delivery of world mental health within this framework invite analysis and critique.

In the eyes of some international actors there are great gains and much progress to be made through organizing and delivering a 'World Mental Health' system of care. In planning globally, services can be administered 'efficiently', quality can be measured and products of knowledge/academia created and disbursed. Pharmacological developments, their sales, professional training in their uses, computer programs for their marketing, and so on are part of a market created in the name of 'World Mental Health,'

The current focus on productivity, work, the 'disability adjusted life years' lost through the 'Burden of Disease', and managing the "scourge of depression" (DeVries, in conference, 2001) points to a direction for the work of those at the helm of the 'World Mental Health' framework. A direction through this framework is to aid the economic development and productivity of already under-productive nations now 'increasingly' plagued by illnesses that rob individuals of the ability to participate in the market economy. In The Gambia and elsewhere, mental illnesses need efficient and appropriate treatment to support the 'development' of these yet 'underdeveloped' countries. A textual analysis of 'The Pathways Study' suggests how it played a small but crucial part in putting into place this 'World Mental Health' frame where the complex Western economic language of DALYs (Disability Adjusted Life Years), "Burden of Disease", notions of productivity and Western psychiatric measures of diagnosis and treatment are

rolled into the common language of a 'delay'. Chapter Four analyzed how using the 'Encounter Form', the first pages of the actual survey of 'The Pathways Study', the mental health worker carried out a full clinical assessment, paying particular attention to the "sequence in which symptoms were developed" (Gater et al, 1991). Here my analysis focuses on how that encounter was constructed to look at that sequencing and to measure particular 'delays' in reaching Western oriented psychiatric service. Through further analysis, the common language of 'delays' can be shown to enter my, and my colleagues', nursing practice in The Gambia.

Text-Reader Conversation:
'The Pathways' texts as elements of social organization

A "text-reader conversation" begins in the 'Encounter Form'. The form is the text that I used to enter the social organization of 'The Pathway Study'. To read it in this manner is to find its textual clues that lead to the discourses from which it originated and they lead, as well, to the 'work' the study is doing in Africa. The text-reader conversation that now takes place (in institutional ethnography) offers me (the analyst) the opportunity to discover the social relations of the setting in which 'The Pathways Study' was done. Of course I was there, reading the 'Encounter Form' and following its instructions, but, as Smith points out, "the everyday world is not fully understood within its own scope. The everyday world is organized by social relations not fully apparent in it" (Smith, 1987, p92). The text-reader conversation that I now conduct allows me to see more than I was able to see when I was conducting 'The Pathways Study'.

As I analyze the 'Encounter Form' and its antecedents as text in this way, I pay specific attention to all aspects of its 'message'. Initials at the top left side of the 'Encounter Form' tell me where this form originated. It offers an authoritative connection from this form and my work on it, back to into the "MNH", the referencing code of the text resources of The WHO research guidelines and protocols (WHO, 1981). I know from my initial contacts with the Gambia office of the WHO that this MNH code indicates a referencing of a grouping of studies, among many, in the mental health division. The title MNH/NAT/87.1 ties the study to the WHO libraries in Geneva that distributes the documents through the national offices (in my case, the capital city of The Gambia). MNH/NAT/87.1 is a code for referencing the document in the vast libraries of WHO material at the offices in Geneva. Thus, I have identified the definitive link not just between that office and 'The Pathways Study', but similarly I can trace the study to the Gater et al (1991) research and other bodies of information that underpin and report on the uses of this text. Gater and his associates at the Mental Illness Research Unit at the University of Manchester originated the study of the "WHO activities aimed at improving the quality of mental illness care" (Gater et al, 1991, p 761).

"Annex 1", at the far top right of the 'Encounter Form', is another identification code that points to how 'The Pathway Study' fits within other WHO studies. This identification situates this 'Encounter Form' as a document annexed from a larger report that outlines a whole program of research. The report itself

names the goals, requirements, protocols, resources needed, methods, and analysis of the various studies. This program report shows how the documents can work together to build a clearer understanding of mental health circumstances, training needs and so on. The aims of 'The Pathways Study' are listed in the larger document as:

> ...to describe the pathways which patients with mental illness take in each centre. For a variety of practical reasons it begins with patients coming to mental illness services with new illnesses, and it aims to answer questions such as the following:
> Pathways of care:
> What paths do people with mental illnesses follow in the course of their search for help?
> How long does it take to pass the various nodes in the path?
> And which symptoms hasten the process of referral to a specialist psychiatric service?

"Annex 1", of that overall program document, draws the study back into the aims and discourses of research where hastening referral to 'specialist psychiatric service' is of particular importance. The temporal component of a concern for the delay in getting patients to Western psychiatric care is noted in this introduction of 'The Pathways Study'. Gater's (1991) work, WHO research templates, and related studies focus on getting "appropriate help (to patients) as soon as possible after the beginning of patient's contact with services" (Gater et al, 1991, p762). All pathways research, it must be noted, assumes the benefits to patients of a quick referral from wherever first contact was made with a service provider – whether that is a general practitioner in Manchester or a local healer in a developing country. This assumption enters my survey invisibly

as a feature of the dominant medical discourse of psychiatry from which Gater's work emerges.

Expediting the WMH Framework: The Construction of Delays

A typical 'Encounter Form' introduces a patient who has one or more symptoms (such as sleepless nights, illusions and so on) and who sought help from some practitioner several months or even years ago. Often the person goes to a local healer and is offered a charm or an herbal remedy. Because a member of the CMHT is doing the survey the list of encounters culminates with his or her encounter with this team member. It is this practitioner (a Western trained professional) who fills out the form and who selects a diagnosis and a treatment. The artefact of the survey cuts off the search for help at this point; the pathways ultimately conclude at the Western psychiatric system in which the 'Encounter Form' interview takes place. It thus offers the impression that the person with the symptoms finds the psychiatric treatment to be a solution. For example a typical journey discovered along a patient pathway was: an initial first pursuit of help to a local healer, then possibly a community health centre, then back to a healer and, perhaps even years later, symptoms recurring, the patient would report as a new user of the Western psychiatric CMHT service. This visit would be the concluding chapter in their journey to help as we could and would record it in the 'Encounter Form'. This is a reading that reinforces the dominant psychiatric discourse.

As I, in the text-reader conversation, encounter the documentation of

'referrals' and how they were made, my reading is informed by the discursive home (of Gater et al's perspectives on 'delays') in which patient's stories are constructed as 'sequences' of help seeking. The pages of the 'Encounter Form' do not just 'record' this information, their categories and instructions to interviewers construct it's meaning. Only when I have the concept of 'delay', as Gater et al developed it in their research, can I interpret the 'Encounter Form' as it should be read. My method of reading relies on the text itself for establishing the 'validity' of the interpretation. The text points to the connections that are to be made back to the authorizing organizations and their discourses.

Gater's research established for the 'World Mental Health' framework the connection between referral to Western-style treatment and 'quality' or 'efficiency' of service provision. Especially in developing countries required to meet monitoring and evaluation standards with efficiency as a focal point, it has become essential to have 'efficient' interventions in mental health to be able to decrease delays and hasten referral to western medical treatment. Gater found that when people sought help from local healers, delays in reaching 'appropriate' treatment were increased. He suggested that when more is understood about patients' involvement with local healers, a variety of ways of 'hastening referrals' (Gater et al, 1991, p773) could be undertaken. Training in recognizing psychiatric symptoms is one of the activities suggested in this work. In our application of 'The Pathway Study' I found that as we became oriented to the format of the study, where symptoms were understood to fit into a category, we

began to read symptoms according to the form, and not necessarily the experience and story of the patient. While this sort of clinical training proposed in the research program is of some benefit, it is not without three key difficulties of (1) reorienting the clinician's interview with a patient to the efficiencies of science, (2) deciding what kind of treatment is ultimately most 'effective' or 'helpful', and (3) discrediting instead of working to support local healing.

In this work of translation, power and hierarchy of the formulations and professional discourses of ICD-10 enter unseen into engagement with mental health problems across the world. The text-reader conversation shows how, through discourses taken from their individual/local context, circumstances and politics, the scenarios are worked up into the common languages of 'delays', diagnostic categories and symptoms. These ideological frameworks operate for the purposes of structured treatment and program organization. Few alternative understandings to the dominant Western perspectives can enter the pathway or analysis. The biomedical and pharmaceutical framework is a point of reference build into the analysis and utility of such studies. The meaning and usefulness of the survey necessitate that the reader holds certain values of where a pathway 'should' lead. The very survey structure is placed in the context of Western organizations, politics, psychiatry, research ideology and corporate affiliation. This artefact carries an assumption that specialist psychiatric treatment and understanding is cross-culturally the best approach to mental health care. In my experience, I have seen how this is not always sustainable, desirable or

beneficial as in the example of our costly medication supplies that were not always available/affordable. Psychiatry responds with psychotropic drugs to disorders that may be culturally or socially specific, such as "depression" in western societies. Some scepticism should be maintained about both what diagnosis and pharmaceutical treatment of symptoms that Westerners see as those of "depression" or "psychosis". Perhaps if we paid attention to what patients actually had to say, we might begin to discover the basis of their troubles and how they might be addressed. As it is, one can imagine a whole continent of oppressed people being further chemically suppressed.

In use, the survey had what I could see as both organizing and disorganizing features; an organizing character for the purposes of dominant Western knowledge and a disorganizing character for local knowledge. When I think of the disorganizing assumptions that the survey texts carry, I am reminded of Nigerian writer Chinua Achebe's (1958) book "Things Fall Apart". Yeats' poem " The Second Coming" forms the title and Achebe quotes:

> Turning and turning in the widening gyre
> The falcon cannot hear the falconer;
> Things fall apart; the centre cannot hold;
> Mere anarchy is loosed upon the world.
> (Yeats, in Achebe, 1958, p1).

Through my questions and the anarchy erupting from the disjuncture of my experience, I have been drawn into this analysis. It is an analysis that has allowed me to hear the falconer, the 'World Mental Health' framework, as it so quietly encroaches.

Chapter Six

Conclusions:
"Stepping Out of the 'World Mental Health' Framework And Into Another Standpoint"

Standing in a different place you see different things. As a result of this inquiry I see 'The Pathways Study', and my place in the world, differently. Through connecting the development and mental health discourses, and the specific activation of the text of 'The Pathways Study' I now see how my experiences happened as they did. I have discovered issues of knowledge as it is organized from a common (usually privileged and dominant) perspective and the knowledge of common everyday work. In a review of the discourses and through textual analysis of the 'Pathways Study', I have shown the construction of common languages as they are developed in the interconnection of a 'World Mental Health Framework' and enacted in the everyday world. It is my claim that this discursively organized framework represents what has become authoritative, common fact and common language in international mental health.

In many ways, on very practical levels, my learning from these discoveries is impacting me still. I will discuss these implications as I conclude and share my discoveries in the areas of 1.)the discourses and organizing frameworks, 2.)the transformation of practices with well-intended but destructive Western biases, and 3.)the issues of common language as practices of dominance.

Seeing the Discourses, Seeing the Organizing Framework

My experience as a development worker and mental health nurse in The

Gambia allowed me to see that a call in the international development sector for improved standardization, management, monitoring and order has been brought to bear on my work in the development of mental health through ideological practices. Through my analysis I have been able to trace how calls for 'better' reporting, quality assurance, standardization, monitoring and evaluation operate in concert with the requirements of the primary funding agency (The World Bank) to poor countries. Coordinating, standardizing mechanisms (of which the ICD-10 is one example) have origins traceable to The WHO and The World Bank, development and mental health discourses; a framework I call the 'World Mental Health' framework.

I was brought within the discursive organization of the 'World Mental Health' framework while working in The Gambia. As nurses with the CMHT, we worked to gain services so that we could care for mentally ill patients. We continually found ourselves required to document and record our experiences and needs in the language of this dominant framework. By explicating the social relations of 'The Pathways Study' that I participated in implementing, I have been able to make many issues and ruling practices visible. I suggest that this cross-cultural, psychiatric, globalization effort operates as part of a ruling regime. The translation practices required to conduct research, monitor/evaluate programs and access funding for services reveals the place of the regime in transforming everyday practice and 'routine clinical assessments', and in dominating and subordinating other alternatives in the name of 'hastening the

referral' to Western medical treatment. In his study "Defense from Mondialization", Samir Amin describes this as imperialism and as a feature of capitalism (1998). I argue that the capitalist enterprise is at work in the subordination of local healing practices (to the point of extinction in many nations) and in the mass marketing of the tools of the ruling regime (namely the ICD-10 and resultant biomedical treatment strategies). The growth and expansion of the pharmaceutical industries market worldwide is a testament to this evangelization. The actors in this social relation of domination are progressively accepting this 'prescribed' progress as an unquestioned reality.

Discovering the discourses of 'Mental Health' and 'Development' I have discovered that a general conceptual framework of 'World Mental Health' is expressed by the official expert knowledge of The WHO (WHO, 1999) and the dominant lending and research institutions. Some of the concepts articulated in strategic plans at the central WHO level, address the identification of target groups (for example, epilepsy and depression), and remark on the magnitude of the problems by way of the DALY measure of the 'Burden of Disease' (Brundtland, 1999). The articulation of such definitions into the diagnostic categories of the ICD-10 (WHO, 1993) is refining the complex nature of creating priorities and programs for mental health care globally (Desjarlais et al, 1995). Definitions and central concepts are brought into practice and activated through research that is continuing to develop and calls for a cross-site, standardized approach. The conceptualizations and methods for implementation of the global

view of mental health are part of an organizational framework. This is a framework that manages and surveys the use of resources throughout the world; it is, in Smith's (1990a) terms, a 'ruling organization'. These research agendas, as technologies of ruling, were explored through textual analysis of my own research work in The Gambia.

Through the institutional ethnography approach, I have been able to see where research fits into a plan of action, what organizations do with the data in order to conceptualize proper action/programs, and make decisions about funding and other program decisions. The discourses in all the fields of mental health and development are not separate, but are integrated, ideologically and practically; and as such construct mental health work as part of the ruling practices of global capitalist domination. It all contributes to the ruling regime. The ruling organizations of the 'World Mental Health' framework have a programmatic sequencing of actions that subordinates local practices to Western priorities. I have experienced this subordination as a practice that both facilitates and constrains the sustainability of support to local mental health services in the often-contradictory field of 'development'. There are aspects of the ruling regime of the WHO's mental health division, research agendas and processes of standardization I see as enormously beneficial to practice. There are contradictory aspects of the development agenda that live as ideological practices serving to subordinate local interests and take for granted dominant discourses as 'right', legitimate, factual and helpful when this is not always the

case and when, in actuality, translation, miscommunication and disorganization of practice occurs.

Understanding Across Differences

In doing cross-cultural work researchers, development and aid workers do try to solve the problems of communication and understanding. In discussion among development and aid experts, a variety of concerns arise about how to speak across differences and communicate effectively when people come from different places. Different approaches are used to help solve the problems that arise; for example research languages offer consistent accounts as in the work Gater et al (1991) and others suggest; other speak about "cultural approaches" and debate the effects of "cultural biases" (Harrison and Huntington, 2000). I suggest that by acknowledging interpretation/translation problems as a 'bias' we risk under-analyzing the ways in which discursive organization can enact dominance and disorganize local practice. A 'cultural approach' to exploring the problems of interpreting health information across differences is prominent, seductive and leads to the blanket escape clause of 'bias' in cross cultural research. That is, all 'difference' is explained as 'cultural bias' and can be the excuse for further dominance and neglect of locally important practices. This seduction points to why problems must be further explored for the sake of looking beyond 'culture' and into the investigation of 'dominance' in research and program development. Analyzing pathways of mental health care in The Gambia within its own psychiatric 'World Mental Health' terms, and overlooking it's social

organization is an example of the characteristic seduction of well intended workers into the discourses of dominance. It is an example of the necessity of the analysis undertaken herein. Through my analysis of the 'Pathways Study' text-in-use I have discovered how the exercise of translation and cross-cultural templates for research transforms practice while standing in for the dominant discourses. The miscommunication or translation exercise is not to be explored here as the nemesis, the destroyer of ideals, but rather as a pervasive feature of our social world.

'Common' Language Explicated: organizational hegemony exposed

In Chapter Four's analysis of the 'Pathway Study' text- in-use, I have shown how the common language of cross-cultural research tools is not common, and part of a 'routine assessment', but rather a practice of domination that transformed our nursing practice in The Gambia. I have shown how implementation of the 'Pathways Study' had our CMHT (Community Mental Health Team) working up our experiences with patients into the categories of the survey 'Encounter Form' and into the common language of the 'World Mental Health' framework. Western psychiatry became the interpretive frame, and common language for which we diagnosed and assigned the appropriate treatment plans to our patients through the structure of the form. In Chapter Five's analysis of the text-reader-conversation, the origins, intentions and meaning embedded in the text of the 'Encounter Form' of the 'Pathways Study' were also explicated. In this process, I discovered the construction of the

measurement of a 'delay' in reaching the Western psychiatric system in the pathway to mental health care. Searching the actual discourses and discursive practices referenced in the survey documents, I was able to understand 'delays' as part of a more general health economic measurement to hasten patients into becoming well and productive members of economic society. As we worked the patients' accounts into the survey format, we created a new account that fit into the intended psychiatric and economic interpretation. Through analysis of the specific technologies of research programs, and the categories of diagnosis I have been able to see how texts constructing 'The Pathways Study' have a language capacity that carries a 'World Mental Health' discourse. These texts also speak to each other and disorganize as they standardize for 'efficiency' along the referral pathway. The analytic tools I employed identified the language and practices in the survey I implemented in The Gambia as nested in and part of larger practices of ruling. The ruling practices exist through the interconnected practices and discourses of aid and loans allocation through the World Bank; research, training and services direction through the World Health Organization; as well as pharmaceutical trafficking through multi-national pharmaceutical corporations.

I have discovered that analysis of the social organization of dominance through ruling practices is necessary in order for those at the table of decision making to acknowledge the inter-woven assumptions and practices of ruling organizations in order to make a place for local language and practice at the

table. A community of speakers with one dominant voice is hegemonic. Rahnema (1997) speaks of the hegemony of a universalist language that, he suggests, "like the global village, tends to destroy the real languages used by millions of people everywhere to express themselves in their world." Universalist, or 'common language' as it is called in the ICD-10, interferes with an understanding that allows people to understand each other and their circumstances in terms that speak to their local experiences and their shared socially organized condition. Unfortunately, most local and extra-locally constructed terms that define the knowing of those things close to people's hearts – such as poverty, sadness, joy, abundance, freedom, help and care – have all been reduced to text, codes or images, called to mean the same thing all over the world. So long as these worlds colonize or 'commonolize' people's languages, it will be difficult to talk seriously about the actual and real problems face in the world. When the context of cultural dominance as well as cultural difference is taken into account for instance, a broader understanding of the communication and translation difficulties emerges. I assert that local decisions in response to these problems should reflect local possibilities, and for this reason one needs to undertake a materialist analysis; to understand what is really organizing the setting as it is.

A materialist analysis shows the construction and enactment of 'common language' and taken for granted practices in our work. It is important to investigate organizations and their practices to understand how local practices

and experiences get 'worked up.' Organizations, in the work of naming the pathogen and treatment, categorizing and organizing, are implicated in constructing messages that omit as much as they say. That which is omitted, in the common language of the ICD-10, or other large cross-cultural research tools and diagnostic or treatment categories, more generally is the actual language of everyday people in everyday life. I am left deeply curious as to what is the everyday language so obscured as interconnected discourses and a common language dominates in the name of progress? Speaking of the legacy of obscured possibilities in colonization established through a "circuit of mutual services and complicity", Cesaire (1998) states:

> I hear the storm. They talk to me about progress, about "achievements", diseases cured, improved standards of living.
> I am talking about societies drained of their essence, cultures trampled underfoot, institutions undermined, lands confiscated, religions smashed, magnificent artistic creations destroyed, extraordinary possibilities wiped out...
> They pride themselves on abuses eliminated.
> I too talk about abuses, but what I say is on the old ones - very real - they have superimposed others - very detestable.
> (Cesaire, p226)

Throughout my work in The Gambia, I sought to help, to eliminate the very real abuses and restraints on patients. Now I am able to see, how the imposition of dominant Western discourses of progress can occur in spite of the best intentions but with further abusive qualities. Cultural imperialism, referred to also as "intellectual fascism" (Banerji, 1999, p227) and "cultural terrorism" (Petras, 1997, p187), can proceed, as I have shown, through a very subtle process of

social relations. Those of us employed as cultural collaborators, working between the local and official modes of knowing, have an opportunity to work to resist the cultural imperialism in our health care work. We must explicate and learn from the hidden social relations.

Personal Learning: The longest journey

As a result of my research, my questions and analysis of social relations continues. I am compelled to look further at how these ruling practices come about, to inform and position myself to choose and to act, critique, question and advocate differently. I am compelled to ask how am I, from my privileged white, academic position participating in the work of the construction of knowledge, and how do I want to participate in this?

I have seen how textual materials can be used as learning activities for students studying social activism in nursing. As my work expands to assist students experiencing development projects and research in West Africa and world wide, it will be essential to introduce these students to the idea of knowledge as organized in different ways. As part of their explorations I see the place for these students to investigate taken for granted materials such as surveys, forms and documents that organizations required for nursing practice and international development work. In addition, analysis of textual materials from the workplace and international organizations can be used as a vehicle to identify otherwise hidden social relations. It is a literacy of sorts that can lead to increasingly informed and empowered practice and navigation of the dominant

organizational regimes. Textual analysis can be used to supplement students' understanding of underlying social relations to increasingly gain access to levels of influence. This sort of awareness offers a fundamental shift in experiencing the ruling regime from a place of literacy without complicity.

Critics of contemporary development are likewise concerned about approaches that seem to homogenize. N'dione et al (1997) speak about rejecting a view of development that suggests dominant knowledge is somehow "valid for everyone". They say:

> What could be expected from this type of development is that it excludes the largest number of people from the processes which serve the interests, the good and the power of a few. It serves to create poverty and exclusion; it is redistribution that should take precedence". (N'dione et al, 1997, p368)

D'dione is talking about the important redistribution of power and influence in "the processes" that set the priorities and interests for poorer nations. "The processes" and priorities for mental health are clearly exclusive, involving the likes of the 'Harvard Report' and other agents of the 'World Mental Health' framework. What N'dione et al (1997) call for is a rediscovering of the sense of how things happen, "to help bring to light those signifiers that create exclusion, that devalue resources and abilities of the people themselves..." (N'dione, 1997, p369). The rediscovery of how to actually see local activities, experiences and priorities will require a dramatic shift in knowing.

Redistribution of knowledge and wealth, and a shift in consciousness from research products to local wisdom has, through this analysis, been brought

to the foreground of the research agenda as I now see it. This new agenda I envision aims to rediscover a sense of the practical everyday, a sense of 'what is actually going on'. Only the patients, nurses and those outside of the ruling regime can carry out a rediscovery of the relevant sense of the expression in the here and now. The consumer/patient activists protested at the World Assembly for Mental Health seeking inclusion and shouted "Nothing About Us Without Us!". The multiple voices of those situated differently and seeing differently than the ruling regime are being, and must be raised. An expanding resistance movement is emerging about the notions of 'development', progress and globalization (Barlow & Clarke, 2001). Our role as members of a privileged society of nations, international organizations, researchers, and practitioners, is to work with an inclusive sense, with a view to facilitating the processes of rediscovering the helping relations amidst diversity versus reinforcing the dominant organizational relations. It is also our role as citizens to encourage the dominant system to value this perception, so that the 'common' voice is no longer only the privileged voice. I have no pretensions about being a new interpreter of local realities, nor of substituting a new prophecy for the dominant one. I feel that the very process or rediscovery however, is a liberating one. I have found there to be a certain freedom in making the space for knowledge understood from outside of the dominating but unquestioned discourses.

Some of the choices and changes I am making in my development work as a result of the learning from this study are increasingly liberating, though no

less influenced by the dominant discourses and the ruling regime of development and international health. A nursing course I am teaching at another university in West Africa addresses the theme 'advocacy'. I am interested in exploring one aspect of advocacy as the illumination of the ruling relations for patients, nurses and administrators. Additionally, as I am collaborating in the production of a village mental health guidebook, I am continually drawn back into the information of the ruling regimes of mental health. I am also interested in shifting the perspectives of diagnosis, treatment and service delivery into one that invites the local order, and honours the strengths and humane practices of indigenous mental health care. As I reflect on program development recommendations for that project, it is interesting to me how entrenched the discourses are in my perspectives! Though I am beginning to see differently from this place outside of the ruling regime the dominant language continues to challenge me.

In spite of the ever-present challenges of domination, the gestures of entering the relationship of exploring what is actually helpful in the everyday to those outside of the ruling regime must persevere. As citizens of the world it is our first step to discover a 'truthful' relationship with the world as it is and to know the 'help' Western organizations and medicine claim to give. We can, through this analysis, begin to look at what is really helpful and what is more focused on organizational relevance that supports the ruling systems.

Beginning and Ending in the Experience

As I worked in The Gambia I both felt the disjuncture in my work and raised many questions. I don't believe I fully grasped the discursive and constructed arrangements of well intentioned and misguided development work practices. Through this analysis, I have grasped a sense that text has colonizing abilities, that colonization does not exist alone, but is enacted by people in the everyday world and mediated by processes and practices that are organizational, institutional and ruling in nature. My analysis has emphasized for me a sense that language, translation and words are powerful in so much as people activate them for particular purposes. Anne Hebert's poem, "The Offended," symbolizes to me the powerful role humans have through taking actions disguised in language, words and text. Hebert states:

> The poor were lined up in famine's order
> The seditious were examined in anger's order
> The humiliated were interrogated in offence's order
> The crucified were considered in mutilation's order
> In this extreme misery the mutes came to the front lines
> A whole nation of mutes stayed on the barricades
> Their desire for the word was so urgent
> That the Verb came through the streets to meet them
> The burden it was charged with was so heavy
> That the cry "fire" exploded from its heart
> Disguised as a word. (Hebert, 1993, p1)

When I read this poem I think about the conditions of the slave trade in West Africa and about the similarities to today's international tragedies of colonization and dominance. Through the discoveries I have made in this thesis, I have a new consciousness of how these scars on the human landscape can so

insidiously occur, and how there are approaches to investigate how words are activated by people like me to construct our world. This approach has entered my consciousness. I would say my consciousness has shifted. I am looking at words, what is known and what I know very differently.

As other problematics emerge in my work and awareness, I am drawn to explore further organizational and experiential fractures. I see the liberation in my process of exploring fractures of knowing, discursively and experientially, in my work in mental health, education, and international development. I have seen how this occurred as a textually organized practice, in a more generalizable feature of capitalism practiced ever-increasingly in our, so-called "interdependent" (CIDA, 2001, p4) or, globalized world. I am all too aware that "the relations of ruling do not disappear by learning about them..." (Campbell, 1998, p70). Ruling relations are ever woven into the fabric of contemporary life. Amidst the cultural bath of fractured realities, weighted by the tensions of working across cultures, knowing about the weave of ruling relations has brought a new perspective to the disintegration and confusion of my re-entry into Canadian life and choices in involvement in the development and international health sector. I have radically re-thought the role, and my role, in direct help, research and knowledge development. I am compelled to pause amidst the fervour, the drive to stop abuses, and the calls for action. I am compelled to consider what it is to provide 'real help' (Hancock, 1989). I am drawn further to investigate and protect the obscured knowing that lives outside of organizational

categories and standards; it knows of a kind of help that lies within indigenous knowledge and interpersonal relationships. In my ongoing cries for peace and patience, I frequently reflect on the wisdom of my CMHT colleagues. Spoken often on our long and dusty CMHT 'treks' in The Gambia, my colleagues' counsel guides me still: "Insallah (god willing), we will soon be there".

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