

**La recherche en santé mentale
et la domination culturelle :
la construction sociale de la connaissance
à des fins de développement international**

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Ce travail ethnographique institutionnel s'appuie sur l'expérience de la première auteure en tant qu'intervenante en développement international, éducatrice et infirmière en santé mentale communautaire en Afrique occidentale, pour illustrer comment la recherche officielle et les politiques portant sur les services de santé mentale reflètent la domination occidentale sur le plan académique, corporatif, économique et culturel. S'appuyant sur une analyse textuelle critique d'un questionnaire utilisé dans le cadre de demandes de subvention adressées à des agences d'aide internationale et de prêts, les auteures démontrent comment les processus officiels privilégient les politiques et les approches de recherche occidentales et supplantent les perspectives locales. Pour être efficaces dans leur travail de développement en Afrique, les infirmières, les chercheurs et les décideurs doivent apprendre à reconnaître les attitudes de domination subtiles inhérentes aux approches occidentales. Les auteurs proposent que la recherche internationale et les politiques de développement international mettent en priorité la compréhension des connaissances locales plutôt qu'une approche privilégiant des cadres d'interprétation complexes et généraux.

Mots clés : santé mentale internationale, domination culturelle, ethnographie institutionnelle

Mental Health Research and Cultural Dominance: The Social Construction of Knowledge for International Development

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This institutional ethnographic work uses the first author's experience as an international development worker, educator, and community mental health nurse in West Africa to illustrate how official research and policy on mental health services reflect Western academic, corporate, economic, and cultural dominance. Focusing on a critical textual analysis of a survey intended to support funding applications to international aid/lending agencies, the authors show how official processes privilege Western policies/research approaches and subordinate local perspectives. If nurses, researchers, and policy-makers are to be effective in carrying out development work in Africa, they must learn to appreciate the subtle exertion of dominance inherent in Western approaches. The authors propose that understanding local knowledge be foregrounded rather than backgrounded to the complex global interpretive frames for international research and international development policy.

Keywords: international mental health, cultural dominance, institutional ethnography

Introduction

The question of ruling practices that masquerade as development is very difficult to pry apart from the ideology of caring that motivates nurses. Those who experience it can feel the contradictions. (Campbell & Gregor, 2002, p. 126)

This institutional ethnographic work questions the assumed benefits of development work in cross-cultural research. It uses the first author's experiences as a development worker, educator, and mental health nurse in West Africa to demonstrate that official research and policy regarding mental health services in developing countries are part of Western cultural dominance. As such, the analysis should serve to further our understanding of the increasingly vocal resistance to international development that sometimes appears to be a generalized critique of globalization. A careful textual analysis of a survey developed by the World Health Organization provides the basis for the argument that official knowledge

about mental health in The Gambia, West Africa, privileges Western ideas and practices. An analytic focus on knowledge is central to this argument. The knowledge generated by surveys such as that of the WHO is crucial to the development and management of mental health intervention programs in developing countries. Yet the knowledge generated and the treatment based on that knowledge are shaped by ideas and interests that are not those of the people they are designed to help.

The analysis was conducted by the first author as part of her master's of nursing thesis (Jakubec, 2001). The second author supervised the research and helped to develop the conceptual framework for the paper. For clarity, the first author's voice will be used throughout. In the thesis research, I (Sonya Jakubec) analyzed my own work in The Gambia to illustrate the contradictory nature of development work in general and mental health nursing in developing countries in particular. On the one hand, mental health patients in The Gambia needed help, and as an experienced Canadian mental health nurse I felt that I had much to contribute to the mental health team. On the other hand, I saw a different picture emerging. What is analyzed is the "help" offered by a well-meaning nurse as part of a "world mental health" framework that carries certain cultural implications.

Background

Between 1996 and 1998 I served as technical advisor to a community mental health team in The Gambia, having been recruited by a British non-governmental international development agency. My responsibility was essentially to assist in building a community health program in this impoverished country. Through orientation programs, I was trained to adapt my skills and knowledge to new, resource-poor settings as well as to customs, ethics, and values specific to The Gambia. I brought with me, as would any Canadian nurse, a respect for the cultural practices of the country in which I would be living and for the views of the four Gambian nurses with whom I would be working. I learned to be attentive to predominant local beliefs and traditional healing methods, which included a belief in spiritual disease causation, extensive family involvement in care, and treatment by healers known as *marabouts*. The Gambian nurses were Western-trained and moved comfortably between Western and traditional beliefs surrounding mental health. The team's work practices had been shaped in the context of diverse belief systems, values, and practices. The population served by the team comprised five main ethnic groups. Most patients approached traditional healers first in their pursuit of treatment for mental health problems. In order to function effectively in this setting, I took local language lessons, participated in an extensive

in-country cultural training program, and attended local ceremonies and other events. I also closely observed and tried to learn from my colleagues and the Gambians who I befriended and with whom I resided. This process of observation, questioning, and immersion was, for me, an important means of understanding nuances, taboos, and cultural mores, and of supervising nursing staff, teaching, and offering clinical guidance to colleagues in an appropriate way.

As I approached the end of my 2 years in The Gambia I began to look for base or long-term funding to help sustain the work of my team. The team had worked hard and accomplished much: the mental health program was growing and was seen as a successful health resource in the country. But I was aware that, as an outsider, I had access to resources that my Gambian colleagues did not. Included in the advice I received on attempting to secure continued funding was a strong suggestion that I collect “better data” on the need for the service being offered, in terms of both the clients and their treatment. I was directed to the Gambian national office of the WHO, where, after some consultation, it was suggested that I begin to collect data on mental health. The Pathways Study material was put in my hands, and I eventually sought and received Canadian government funding to conduct a study. After completing one term of a master’s program at the University of Victoria, I returned to The Gambia in 1999 and conducted the study as a member of a large team of mental health workers. The Pathways Study consisted of a questionnaire administered during routine “encounters” with new patients over a 1-month period. There are several pages on the patient’s history of being examined, diagnosed, and treated over the course of an illness or series of illnesses up to the point of the present encounter with the psychiatric system. This paper does not report the findings of the Pathways Study nor critique the questionnaire itself. Rather, it concerns the construction of knowledge *through* the Pathways Study.

Institutional Ethnography

Institutional ethnography is an approach to studying everyday life in which the analyst looks at “how things are organized.” It draws on Dorothy Smith’s (1990a, 1990b, 1999, 2002) theory of the social organization of knowledge, in which “experience” is the starting place for an inquiry. Something that is experienced by an actual person in an actual setting is examined in order to discover the forms of social organization that constitute it as it is known and responded to by insiders (Campbell, 1998). The notion of “standpoint” is central to Smith’s institutional ethnography. Knowing and knowledge, Smith claims, are always located somewhere; thus an institutional ethnographer works from and “expli-

cates” a problematic from a particular standpoint. Smith’s interest in developing a methodology for social analysis that attends to a particular standpoint emerged from her (feminist) concerns about men’s views being taken as normative (Smith, 1987). Smith and other feminists have suggested that the subordination of women originates in just such “invisible” knowledge practices. This view has strong appeal for nurses whose experiential knowledge lacks professional authority. It can also be useful in analyzing the troublesome issues of post-colonial development work. Smith takes Foucault’s (1984) view that knowledge and power are linked. Smith’s commitment to social equality brings to her scholarly research a theorized interest in identifying the role of power in the knowledge practices that permeate everyday life. She argues that people’s lives are ruled, at least in industrialized societies, by the textual coordination of action (Smith, 1990b). In institutional ethnography, the goal is to determine empirically how that kind of rule is organized and how all of those involved (both the ruled and the rulers) make it function. This analytic interest points researchers towards textual analysis and text-based or mediated practices.

Institutional ethnography was the methodology of choice for my investigation, because it offered a way of analyzing the Pathways Study texts, the use of which became a condition for securing further support from aid/lending agencies. The whole scenario surrounding the Pathways Study had been puzzling me. That is to say, it was not immediately clear to me why any new account of the work of my mental health team was necessary given that information on our work in The Gambia had already been collected. Smith’s writings on the social organization of knowledge offer some insight. She explains that texts function as part of the social relations of any setting and serve to unite people in coordinated action. Such a conceptual framework seemed useful for my attempts to understand the contradictions and conundrums I saw in the demand for “better data.” It offered me a way of treating the Pathways Study as a step in the textual organization of “getting mental health work done.”

An institutional ethnographic inquiry is framed, not around a hypothesis, but around a problematic “in the everyday world” (Smith, 1987). The underlying belief about social reality (ontology) is that people “enact” social life; thus a social inquiry must be framed in such a way as to capture accounts of what people do (Campbell & Gregor, 2002, pp. 90–91). All research strategies are approaches to the analysis of data, but they do so in different ways. The institutional ethnographer focuses on how people’s actions, lives, and experiences are socially organized. Smith’s (1987) concept of social relations is central to such inquiry. Social relations is an ontological notion about social life whereby people act

knowledgeably as they conduct their lives and are therefore participants in weaving their personal actions into the social fabric. The goal of the institutional ethnographer is to explicate how people's actions are socially organized and put together to result in what is observed and recounted. Informants understand the meaning of their everyday experiences but do not have a firm grasp of the social organization of these experiences. My explication draws what is missing in people's stories, or in observational data, into the analysis. Ethnographic data provide clues to connections between everyday life and its social organization. The institutional ethnographer follows these outwards to their source. This is how the notion of social relations as organizing the setting becomes a methodological tool. The research questions were: *How does the Pathways Study work? What are its governing social relations? What does it accomplish?* Treating the Pathways Study as governed by social relations serves both to identify the impetus for and implementation of the Pathways Study and to determine how, on the basis of the study itself and the knowledge it generates, a continuing coordinated action occurs. The data of analysis were the study itself — its texts and their origins in various discourses — and the methods I used in conducting the original study.

Data

Institutional ethnography's focus on the social organization of everyday life calls for two levels of data (Campbell & Gregor, 2002, p. 60). The first is ethnographic, in the anthropological sense, and may include interviews or, as with this inquiry, participant observation. My work as a technical advisor included experiential involvement in everyday mental health work, with colleagues and patients, in The Gambia. This experience was my means of studying the organization of the everyday work of mental health nurses in The Gambia. My accounts were supplemented by entries in a journal that I kept on my experiences as a practising nurse and development worker, photographs and slides documenting the workings of the team, and letters that I had sent to colleagues, friends, and family members in Canada.

The second level of data consisted of the Pathways Study documents, the actual survey instruments, and several of the completed questionnaires. The inquiry also entailed a search of the literature on the Pathways Study — its origins and various applications — and a search of the development literature.

Analysis

As the mental health team "activated" the text of the Pathways Study in The Gambia, we participated in its social relations. Smith explains that

texts carry social organization across the experiential boundaries of settings. The activation of the survey form brings its organization into the local setting. For Smith, “texts speak in the absence of speakers” (1990b, p. 211). As we nurses activated the text, we began to relate to our patients *through the form*. This section of the paper analyzes this process, using the text as data explicated through institutional ethnography.

Organizing and “Encountering” Patients: Not So “Routine” Information

At the top of the first page of the Pathways Study is the title “Encounter Form,” followed by several lines of instructions to guide the interviewer’s “encounter” with the patient. Health workers are instructed to carry out their “usual full clinical assessment, with particular attention to the sequence in which symptoms were developed” (WHO, MNH/NAT/87.1).

The basic data to be collected (see Figure 1) were the name of the facility at which the patient was seen, the name of the nurse who filled in the form, the date, the patient’s initials, the date when the patient was first seen by any mental health service, the date when symptoms first appeared, the time elapsed since the symptoms first appeared, and the diagnosis (translated into the language of the International Classification of Diseases-10, or ICD-10; World Health Organization, 1993). Other data to be collected were the name of the person who first saw the patient, how that contact was initiated, the symptoms that caused the patient to seek help, and any specific treatment. This process was to be repeated for any and all other referrals described by the patient.

Activating the Encounter Form

My experiential account indicates that as the text was activated it began to demonstrate cultural domination. I begin by arguing that the “usual full clinical assessment” conducted by my mental health team could be described as anything but routine but transferring these assessments to the Encounter Form began to make them so.

As The Gambia’s only community mental health service, the team had to journey to remote areas of the country in what were called treks. Just getting there was an adventure, owing to the rugged terrain, lack of secure supplies of fuel, and other factors. As we travelled throughout the country, we would see both registered patients and their relatives, brought along as new consultations. Sometimes the queue would comprise hundreds of people, while others would wait outside seeking the shade of trees. Still others would be seen along the way at the compound of the local *marabout*. The team functioned in an informal manner. We would visit people in their homes or, in the case of the smaller health centres, at

Figure 1 *Excerpt from a Completed Encounter Form*

1. BASIC INFORMATION
1.1) Name of facility at which the form is filled in: <i>CMHT office</i>
1.2) Form filled in by: <i>MA</i>
1.2) Date: <i>31 May 1999</i>
1.4) Patient's initial: <i>MJ</i>
1.5) Date first seen by mental health services: <i>31 May 1999</i>
1a.) What was the first symptom developed by the patient?: <i>Isolative, loss of appetite</i>
1b.) How long ago? (number of months): <i>3 years</i>
1c.) State diagnosis: <i>Schizophrenia + specific ICD-10 classification number XXXX</i>
(WHO, MNH/NAT/87.1)

tables set up outdoors under a gazebo. Occasionally we would make an initial or follow-up assessment at the riverside, at the roadside, or in a store.

As with all interactions in The Gambia, every conversation with a patient, family member, or member of the health centre staff began with an exchange of greetings, ritual questions/answers, and blessings/prayers. The Gambia being a small country, the Gambian nurses on the team would often run into extended family members or acquaintances. As we moved about the countryside, the team members would chat with various people, from the patients with mental illnesses, to their relatives and friends, to village leaders and rural health workers, thereby establishing personal connections. An interview might be brief, but it would be filled with laughter, village news, or the stories of the people or families being assessed, often shared over food, which was almost always offered to us at some point in the journey. Rarely would the mental health team consult with a patient alone. The entire family might be present if the assessment took place in a home. Visits to the local healer, where perspectives and treatment strategies would be shared with the *marabout*, were an opportunity to engage in the kind of informal education in which the team specialized. Often the cause of a disorder would be interpreted as personal or social distress, misfortune, loss, or extreme poverty, possibly connected to what was referred to as a *juru*, or curse. The *marabout* would offer charms, prayers, or spiritual healing for the manifestations of the curse.

The Pathways Study transformed the team's way of conducting routine assessments. The questionnaire served as a template for our interactions, with the nurses interviewing people in order to get specific

answers and interpreting their comments in terms of the survey categories. With the increased emphasis on diagnosis came an increased emphasis on “appropriate” treatment — that is, Western psychiatric treatment.

I noticed that my colleagues seemed to enjoy working with the questionnaire. As suggested in the instructions, it was easy to implement, eliminating some of the conversation and informal interactions in the interview process. I sensed that the Gambian nurses found that using the structured, standardized tool and writing down their findings enhanced their “professionalism.” The survey structure also facilitated the team’s control over the queues. One day I was surprised to hear one of my colleagues shout “Next!” as he processed the patients. This struck me as a complete departure from the usual conversational approach whereby patients were treated as members of families and communities.

It was not just the style of interaction that changed. The questionnaire itself altered basic understandings of mental health and proper treatment. It required the interviewer to interpret people’s stories in terms of psychiatric and Western medical notions of causation and treatment. One woman’s first symptoms, as told to a *marabout*, are recorded on the Encounter Form as “meditates a lot, withdrawn, thinking too much (not able to bear children).” After several months her symptoms worsened, to include “tearfulness, insomnia and loss of appetite.” When the woman approached the community mental health team she was given a diagnosis of “depression” and prescribed medical treatment. The actual availability of such prescribed medical treatment would vary. The Gambian state supplemented what medications could be obtained through the WHO drug programs, and occasionally well-intentioned donors would send supplies of psychiatric drugs that were made available as a one-time-only gift. However, a chronic shortage of medications did not affect the team’s evolving understanding of the “best way” to treat patients.

The Encounter Form required that local needs and mental conditions be reported in institutional language. To complete each survey, the team would take an observed case (already worked up through the questions of the trained mental health nurse), interpret the symptoms based on Western notions of causation, and make a diagnosis. This activation of the text would, as in the above example, translate a person’s suffering into “depression,” a condition to be treated pharmaceutically.

Pathways Texts as Elements of Social Organization

My text analysis also explicates the relation between the survey text that we used in The Gambia and a number of mental health and international development discourses, reinforcing my argument that the Pathways Study is a form of cultural dominance. The theory of institutional

ethnography tells me that texts “carry” and establish certain relations among the people who read and use them. My inquiry was directed at the trans-local relations being organized in The Gambia through our participation in the Pathways Study.

In practice I acted as a member of the team, completing Encounter Forms according to the instructions. However, 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” (1987, p. 92). People make sense of texts in the context of their social situation (McCoy, 1995), consciously and unconsciously interpreting and giving meaning to texts from external settings and drawing them into their own, everyday worlds.¹ Smith (2002) further explains:

Texts as read and written in the everyday actuality of people’s work coordinate what people are doing in one local setting with work done by others elsewhere or at different times... Not everybody reads a given text in the same way, but for every site into which a given text is inserted one side of the text-reader conversation is fixed and unchanging from site to site to site. (p. 34)

When people engage competently with texts such as surveys and other data-collection tools, they use the resources of the text itself to determine how it is *intended* to be read. Thus informed, they are able to understand and follow the instructions as well as the unwritten rules. The practitioner’s competency with the text’s words and symbols makes possible the application of some of the text’s meanings to the local setting. In terms of my research, this meant investigating the discourses whose meanings are (or will be) drawn into the local setting through the various ways that the Pathways Study and its findings are (or will be) activated. This text-reader conversation begins with the Encounter Form, my analytic entry into the social organization of the Pathways Study. To read the text analytically is to search for clues to its discursive origins. I need to know what extra-local messages are carried into my work setting. These connections lead to a fuller understanding of what the Pathways Study is doing in Africa and elsewhere.

The Encounter Form provides a number of textual clues to its discursive antecedents. Initials in its top left corner inform the reader of its origins. A referencing code, “MNH,” makes an authoritative connection between the form and WHO research guidelines and protocols. I knew from my initial contact with the WHO’s Gambia office that MNH refers to a group of studies within the WHO’s mental health division. The title

¹ This kind of text-reader conversation in institutional ethnography draws on Smith’s (1999) engagement with Russian language theorists such as Bakhtin (1981) and Volosinov (1983).

MNH/NAT/87.1 ties the Pathways Study to the WHO libraries in Geneva that distribute the documents through its various national offices (in this case, in the capital city of The Gambia). Thus, I identified the definitive link not just between the Gambian national office and the Pathways Study, but also to its initiators, Gater, Almeida, Sousa, and Barrientos (1991), and other discussants of the Pathways Study. Gater and his associates in the Mental Illness Research Unit at the University of Manchester report their research in an influential article, “WHO Activities Aimed at Improving the Quality of Mental Illness Care” (1991, p. 761). Their work in initiating the Pathways Study is vital to how the survey is to be read. It establishes the WHO’s methodology for improving mental health as expressed in the survey and other documents.

The reference to “Annex 1” at the top right corner of the Encounter Form is another indication of how the Pathway Study fits within the WHO’s other studies. It identifies the Encounter Form as an annex of a report that outlines a whole program of research, including the goals, required resources, protocols, methods, and analyses of the various studies, thus showing that the documents can, in combination, build a clear understanding of mental health circumstances, training needs, and so on. The chief aim of the Pathways Study, according to an introductory document, is “to describe the pathways which patients with mental illness take in each centre” (WHO, MHN/NAT/87.1) This introductory document reveals other aims and discourses of Pathways research (see Figure 2). Quick referral to a specialist psychiatric service is particularly important. Concern about delays in getting patients to Western psychiatric care is Gater’s motivation for initiating the Pathways Study — “appropriate help...as soon as possible after the beginning of patient’s contact with services” (Gater et al., 1991, p. 762). All Pathways research, it should be noted, assumes the benefits to patients of a quick referral from the time of initial contact with a service provider, whether a general practitioner in Manchester or a local healer in a developing country. This assumption is implicit in the research as a feature of the dominant medical discourse of psychiatry in which Gater’s work is rooted.

Pathways Survey and the Construction of “Delay”

A typical completed Encounter Form concerns a patient with one or more symptoms (such as sleeplessness or illusions) who had sought help from a practitioner — often a local healer who provided a charm or a herbal remedy — several months or even years previously. To properly read the Pathways data on “referrals,” one must be familiar with Gater et al.’s (1991) perspective on “delays” as manifested in the questionnaire. The questionnaire constructs a patient’s story as a sequence of help-seeking. A proper reading (and activation) makes note of the length of time it

Figure 2 *Aims of the Pathways Study*

For a variety of practical reasons it [the survey] 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?

(WHO, MNH/NAT/87.1; italics added)

took the patient to reach some form of Western psychiatric assessment (presumably, the encounter during which the questionnaire is completed). The categories and the instructions to the interviewer construct each case in terms of the survey's meanings. Implicit in the text are connections to the authorizing organizations and their discourse. Only when the concept of "delay" is seen as developed by Gater et al. can the Encounter Form be read in this way.

Gater's research establishes a connection between local and extra-local sites, between efficient referral to Western treatment and efficient service — those who seek help from local healers are likely to experience delays in accessing "appropriate" care. Once patients' involvement with local healers is understood, Gater et al. (1991) suggest, a variety of ways of "hastening referrals" (p. 773) become possible. They recommend training in recognizing psychiatric symptoms. Recall that in implementing the Pathways Study I observed some negative effects of "hastening referrals" in this manner. As my team became orientated to the Encounter Form, whereby each symptom must fit into a diagnostic category, they stopped paying careful attention to the patient's account and began associating symptoms with a diagnosis. While the sort of clinical training suggested by the Pathways Study can be beneficial, it can also give rise to difficulties. Once the focus is on delay in access to Western treatment, the practitioner-patient interview becomes based on efficiency. This reliance on Western science to diagnose a condition and prescribe the most "effective" or "helpful" treatment sits in contradiction to the lack of medical resources in many developing countries — potentially, however, creating new markets for Western corporations. Underlying such interventions is the danger that traditional approaches will be subordinated, displaced, and discredited.

Delays and “Development”

How can this happen in the context of international development, which would seem to have a philosophy entirely different from that of business? My text-reader conversation offers some insights. Reading a mental health text to determine its social relations leads one to question the research interest in what international health experts call “the burden of disease.” This concern fits with the World Bank’s interest in efficiency and productivity as laid out in the report *Highly Indebted Poor Countries* (World Bank, 2002). Desjarlais, Eisenberg, Good, and Kleinman (1995) describe the connection among health, health care, and productivity: the burden of prolonged illness, in terms of loss of productivity, on individuals and families is considered to be one of the most significant health and social problems internationally. The increasing interest in promoting and studying the pathways that patients take in accessing appropriate psychiatric care is expected to have an economic pay-off (Gater et al., 1991; Sartorius & Harding, 1987; Sartorius et al., 1993).

The World Bank, through its Mental Health Policy Department, closely monitors the financing of mental health services. It issues mental health “do’s and don’ts” for both donors and countries seeking loans or other forms of funding (World Bank, 2001). For instance, the information collected via the Pathways Study is intended to assist the Gambian government. In 1999 The Gambia was preparing a Five-Year Health Action Plan to obtain training resources from the WHO and to obtain aid from international funding/lending bodies such as the World Bank and the International Monetary Fund. Marten de Vries, Secretary General of the World Federation for Mental Health, has cited the role of “productivity, work, and the ‘disability adjusted life years’ lost through the ‘burden of disease,’ with managing the scourge of depression” (de Vries, 2001). This helps to explain the rationale of hastening psychiatric referrals in order to promote productivity. The Pathways Study is part of what I view as the “world mental health” framework (Jakubec, 2001, p. 7), whose purpose is to support the economic development and productivity of “under-productive” nations — nations that are increasingly plagued by illnesses that rob individuals of the ability to participate in the market economy. In developing countries such as The Gambia, according to this discursive framework, mental illness must be treated efficiently and appropriately in order to support development. Development is guided and supported by aid and lending agencies that, while “helping,” also have a distinct view of how such development should proceed. All of these activities, and their textual representations, I suggest, are the basis of a new form of colonization through development, international aid, and tied trade.

Explicating Everyday Practices of Dominance

“Why do they hate us?” (Davis, 2002). Events in the past year have prompted North Americans to reflect on this question. I suggest that nurses who are involved in international development are implicated in some of the practices of dominance that arouse hatred internationally. I have analyzed common research tools to illustrate that their texts have colonizing implications. Mental illness is a problem that people in developing countries need help in overcoming. Sometimes the products of Western research and development will be the solution. Clearly, however, the mental anguish faced by people living in abject poverty cannot always be explained by psychiatry nor properly treated with pharmaceuticals. Methods of knowing that interpret local conditions in terms of psychiatric categories are part of the problem. The results of my analysis suggest that we can best understand the colonizing implications of this kind of interpretation of people’s experiences by first acknowledging our own complicity in the process. This analytic agenda aims to recover an account of what is occurring in everyday practice — behind the slogans — in the developing world and elsewhere. This kind of analysis can contribute to a new way of thinking and to ways of working that actually address people’s needs.

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Authors' Note

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