Do not forget culture when studying mental health

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In today's *Lancet*, Oye Gureje and colleagues[1] add to the growing epidemiological literature on mental illness in Africa. They identified high rates of current and lifetime depressive symptomatology in elderly Nigerians, with a focus on major depressive disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders version 4 (DSM-IV). This study adds to an increasing body of global mental health research which has received renewed attention after Desjarlais and colleagues' world mental health text[2] and WHO's 2001 report on mental health,[3] which raised awareness of the importance and severity of mental illness around the world. Much of this research, including that reported by Gureje, assumes that descriptions of mental illness developed in one set of cultures are equally applicable to other cultures. But if this assumption is incorrect and the nature of emotions, thoughts, and behaviours can be expected to vary by culture,[4] uncritical application of standard diagnostic criteria (such as the DSM) cross-culturally might yield misleading or erroneous results where such criteria are locally inappropriate.[5-6]

Incorporating culture-specific information into epidemiological research is a challenge, particularly for large cross-national studies. For example, the World Mental Health Survey Consortium[7] measured psychopathology in 14 countries, and took steps to incorporate local idioms in the translation of their assessment tools. But the researchers acknowledged that the performance of the instruments might still have been compromised in populations where local concepts and phrases used to describe syndromes are different from the concepts on which the survey instruments are based.

Does this mean that instruments and concepts developed in industrialised countries are irrelevant for studying mental illness in other contexts? Not necessarily. Rather, their appropriateness will vary across cultures and by illness, and therefore needs to be explored. Investigation of local syndromes thus becomes a necessary initial step in the evaluation of the validity and utility of concepts and instruments developed in different contexts. When there is evidence that major depressive disorder, or any of the problems that are the subject of global investigation, exist in forms similar to those cultures for which there are standardised instruments, the use of those standardised instruments makes sense. In cases where the evidence suggests poor agreement, new instruments need to be created. And in situations where there is little or no data about agreement, additional information needs to be collected. Gureje and colleagues acknowledge this challenge when they note that the predictive validity of DSM-IV-defined major depressive disease remains to be determined in an African setting.

While anthropologists have traditionally supported this view, public health and medical researchers have been slow to use methods that incorporate culturally specific information. There are exceptions, such as research on trauma and post-traumatic stress in Indochinese refugees,[8] the Phan Vietnamese psychiatric scale,[9] and measures of mental illness in Native Americans.[10] Our team of investigators, from the Applied Mental Health Research group, has approached this challenge by using both qualitative and quantitative research methods to understand the local context and create locally valid instruments. These methods generate information about syndromes from the study population's perspective and can be used to validate adapted assessment instruments. For example, in Uganda, members of our research group identified local depression-like syndromes with a series of qualitative interviews,[11] and used this information to select a standard assessment tool, adapt it for local use, and test its local validity.[12] As we have continued to use this approach, we have confirmed that in some situations it is possible to use instruments developed in industrialised countries with varying degrees of adaption, while in other situations completely new instruments are needed.[13]

The recognition of the effect of culture on the understanding of mental illness cannot be an after-the-fact consideration. Understanding local concepts of mental illness and of specific syndromes needs to be the starting place to create locally appropriate study instruments that can be used for measurement of prevalence and incidence of illness and evaluation of the effectiveness of innovative intervention strategies.[13,14] Without such knowledge, we will continue to be stuck with the "unsure of cultural appropriateness" caveat as a limitation in research, rather than knowing whether we have captured the mental health problems we seek to understand.

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Users' networks for Africans with mental disorders

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Users' networks for people with mental health disorders have emerged in Africa over the past 5 years, notably in Zambia, Uganda, Tanzania, Kenya, and South Africa.[1] These organisations believe in users' power to strengthen their sense of identity and improve the situation in their communities and countries. Users' networks organise activities such as awareness campaigns and self-help projects, and they contribute to the development of mental health services, springing from the desire to attain human freedom that governments and communities continue to ignore.[2]

In Lusaka, Zambia, where there is a population of 2 million, the number of registered members is 220 of the estimated 30 000 people with mental health disorders. The remaining people with mental disorders are being reached through a track and trace project in conjunction with the government. The network in Zambia has a close working relationship with the government, which financially supports some programmes. However, funds to support the network's activities are still scarce, making it difficult to operate effectively.

According to the 2004 World Mental Health Survey,[3] 200 000 people with mental health disorders (of an adult population of 5 million) in Zambia are not treated in an evidence-based manner. Most have been neglected, whereas others are hidden away by families that are ashamed of having a relative with such a disorder. A case study about stigma and discrimination against mentally ill people in the Lusaka community, which was done by the Zambian users' network and sponsored by the World Psychiatric Association, showed that people with mental health disorders are not treated with respect, are neglected by families, and are denied opportunities for self-development.[4]

Zambia has an extended family system that harbours several cultural beliefs and practices—eg, bewitchment, sorcery, demonic possession, and ritual cleansing—which have implications for the mentally ill and for people's perceptions of mental illness.[5] The community perception is that people with such disorders are violent and dangerous, and hence should be locked in institutions or excluded from society because they are regarded as being unable to lead a normal life.[6] Unfortunately, these practices delay people from seeking mental health services and interfere with the modern treatment of mental illness, which can contribute to some patients becoming chronically ill. Subsequently, families tend to suffer the burden of care with the search for treatment consuming meagre resources. This burden of care becomes frustrating, leading to hostility towards people with mental disorder and promoting admission to hospital or abandonment.[7]

As Gro Harlem Brundtland said in the 2001 WHO report,[8] scientific knowledge about mental illness is available and there is no need for communities to still