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Language, Culture and Mental Health

Philip Thomas, Pat Bracken, Mohammad Shabbir, Salma Yasmeen

اللغه ، الثقافه والصحه النفسيه

فيليب ثوماس، بات براكين، محمد شابير، سلمى ياسمين

Abstract

The increase in cultural and linguistic diversity of contemporary societies poses major challenges to mental health services across the world. Is it possible to work in ways that respect cultural and linguistic difference in multicultural societies? In this paper we focus on the difficulties raised by the use of interpreters in the diagnosis of depression. We use a simple thought experiment in the form of two fictitious vignettes to highlight important features of language-games, an idea introduced by Ludwig Wittgenstein in his late work, *Philosophical Investigations*. The thought experiment draws attention to the importance of culture and contexts in understanding the meaning of what people say when they feel sad. This is even more important in understanding the help that people expect under these circumstances. This has implications not only for how we understand the role of interpreters in clinical settings, but more generally it draws attention to the importance of respecting the many different understandings of sadness and unhappiness that are a prominent feature of non-Western cultures. We conclude attempts to impose Western biomedical interpretations of sadness and suffering on people from non-Western societies has no ethical basis, and is to be avoided.

Key Words:

Psychiatric Diagnosis, Depression, Non-Western understandings, Interpreters, Diversity, Language-games

Declaration of interest: None

Introduction

In common with other European countries, British society is becoming increasingly multicultural, and as its cultural diversity grows, so does its linguistic diversity. In 2001, about 8% of the population identified themselves as belonging to ethnic minority groups. Indians are the most numerous, followed by Pakistanis, people from mixed cultural backgrounds, Black Caribbean's, Black Africans and Bangladeshis[1]. Over 300 different languages are spoken by London schoolchildren[2], and 18 per cent of the population of London speak a first language other than English at home[i]. This poses an enormous challenge to health workers, especially those working in mental health.

In this paper we argue that in mental health, language and culture are inextricably linked. The words and language we use to communicate with

each other reveal how we make sense of our experiences, and the sort of help we expect. Both are heavily influenced by our cultural origins, a point made by anthropologists for many years now[4,5,6]. Here, we make a broadly similar point, but from a different perspective, that of the philosophy of Ludwig Wittgenstein. We do not intend to present a detailed analysis of his ideas here; this can be found elsewhere[7]. We will, however, present a simple thought experiment to illustrate how his later philosophy of language can help to clarify the relationship between language and culture. Thought experiments have been used in Western philosophy for thousands of years to employ imaginary situations to explore reality. The form our thought experiment takes will be familiar to clinicians, two fictitious vignettes about women from different cultures who present with sadness. At the heart of our argument is a philosophical view that sees language as a tool used by human beings to convey meaning. This sees language not as something located in an individual mind, but as part of a wider set of communal symbols that are vital in the construction of meaning.

Language and diagnosis in psychiatry

Assessment and treatment in psychiatry is contingent on good communication between the clinician, patient and carer[8,9,10]. Good communication depends upon the clinician's fluency in the patient's language, the patient's fluency in English, and the availability of an appropriate vocabulary in the patient's language for signs and symptoms of mental illness set out in Western diagnostic systems. There are several problems here. Many people from Black and Minority Ethnic (BME) communities, especially elders, do not speak English[11,12,13]. Ideally, the patient should be assessed by a clinician who speaks the patient's language and belongs to the patient's culture, but this is rarely possible. Shah[8] has drawn attention to serious practical difficulties in interpretation. Of particular significance here is the lack of a matching vocabulary for the symptoms of psychiatric illness in the patient's language. The clinician may struggle to ask questions on symptoms based on Western diagnostic classifications, when, for example, there is no matching vocabulary for depression in Urdu. We can understand these problems through two vignettes. They are not real cases, but the stories are typical of those of many people. However, a caveat is necessary. It is not our intention to reduce unique human subjects to crude cultural categories, and through cultural stereotyping disregard the uniqueness of the individual. That said the two stories are idealised so as to reveal important links between language and culture in understanding distress.

'Mary'

Mary, a 55 year old White British woman, born and brought up in

Nottingham, is brought to see her GP, Dr Wilson, by Sheila, her best friend. Mary's three children have grown up and left home. The eldest son works in a bank, another son works at a call centre, the youngest (daughter) is at university. After marrying at the age of 20, she worked for a while before looking after her children when they were babies. Over the last fifteen years she worked as a secretary, but was made redundant two weeks earlier. Three months ago her husband died suddenly of a CVA. Mary tearfully told the doctor that she had been feeling depressed (her word) and that she had been crying a lot. On direct questioning she told her doctor that her concentration was poor and she had been forgetful. She had lost appetite and her weight had fallen by 5 kg over three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. At times she had felt that life wasn't worth living, but had no plans to end her life. Her physical health was otherwise good, and a physical examination was normal. On being asked, Mary told her GP that she felt she was 'useless' as a person and that she thought she was 'depressed'. On further prompting, she said she thought tablets might help, and she also asked for counselling. The GP gave her a course of antidepressants, and arranged for her to see a cognitive therapist in the surgery. Three months later she was back at work, feeling much better.

'Fatima'

Fatima, a 55 year old woman born in Pakistan and who speaks little English, is brought to see her GP, Dr Khan, by her daughter, Saima. Fatima's three children are all still at home. The eldest son works in a bank, another son works in a call centre, the youngest, Saima, is at university. Fatima came to Nottingham in England straight from Lahore when she married her husband 35 years earlier, and since then had stayed at the home, looking after her children and family. Three months before she presented to her GP her husband died suddenly of a CVA. Since then the family has experienced financial hardship. Fatima has had to handle all the family's financial affairs, something she has never had to do before. Saima tells the doctor that the family are very concerned about her. They have noticed that she is forgetful and cries a lot. She has lost appetite and her weight had fallen by 5 kg in three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. When asked, she tells the GP through her daughter that she believes that she is physically ill. She tells the doctor she wants tests to find out what the problem is. The GP wants to ask her does she feel depressed, but he pauses at the threshold of a familiar problem; he does not know how to ask that in Urdu. Instead he asks how has she has been feeling. She says she feels her heart is sinking, that she is letting her family down because her daughter has had to have time off from university to help her sort out the finances. She has also been praying a lot, and reading the Qur'an. The GP explores with Fatima and her daughter what do they think might help. Fatima says she wants to talk about her experiences. Dr Khan refers her to a group of Muslim women who have similar problems, and who gain strength by praying together. Three months later she is still attending the

group, and with her daughter's help she is taking control of the family's finances. She is feeling much better.

Language, Games and Meaning

What does a comparison of the two women reveal? First, there are similarities. They are the same age; both have lost their husbands, and have children of the same age and gender. Both present with identical physical manifestations of distress, and both appear to be doing much better three months later. There the similarities end. In terms of gender roles, an important part of Mary's life has been her work outside the family as a secretary. This, together with the fact that she presents with her best friend, suggests that a significant part of her identity is invested in areas outside the family. Her children have grown up and left home so she has a dispersed nuclear family structure. On the other hand, the most important aspect of Fatima's life is her role as wife and mother within the family. Within that context her identity has largely been defined by her relationships within the extended family. She has had few if any responsibilities outside home and family, consequently the death of her husband has had major repercussions in this area of her life. The importance of her role in the family can be seen in the fact that her daughter accompanies her to the appointment.

An important assumption in psychiatry is that scientific methods of diagnosis and treatment provide a comprehensive account of distress and suffering. We can see this in the way that evidence based medicine dominates clinical practice in psychiatry[14]. It can also be seen in the influence of Jaspers, who argued that the interests of scientific objectivity require that psychiatrists strip patients' experiences of values and contexts. The problem is that the interpretation and meaning of human affairs is heavily dependent on those values and cultural contexts. This is especially so when it comes to the language we use to talk about our experiences. One way of examining the different ways in which these two ladies talk about what appear to be identical experiences is to think of them in terms of language games.

The philosopher Ludwig Wittgenstein[15] introduces the idea of language games to show that our use of language is a communal activity. A game is usually (not necessarily) a communal activity in which our actions towards each other are determined by a set of rules. Although games take many forms, we all know in broad terms what they are. Some, like football or cricket, involve teams. Others, like tennis or chess, involve two individuals. Some card games like solitaire rely on a single player. It is almost impossible to specify a set of universal rules that would enable us to capture the essential features of all games. All we can say is that there are family resemblances between some human activities that enable us to identify them as games. However, we can say that the rules and expressions

associated with each of these different games originate in the historical and cultural activities that are unique to that particular game. For example, the activities that over time gave us the rules and language of the game of tennis, did not give us the rules and language of the game of football. The two games have different languages and rules because they originated in different traditions with different histories. To use Wittgenstein's words, they arose out of 'different forms of life'. Tradition, history and culture are really important here; they matter to us. Playing tennis, like any game, has meaning for those who play it in terms of a shared history in which the game, its rules, actions, and terminology, bind us together.

Wittgenstein points out that we can say much the same about the different ways in which we communicate through language. For example, we can make a polite request, issue an order, tell someone of our love, attempt to describe the smell of rain in the garden at dawn, or tell a close friend that we feel sad. According to Wittgenstein there are an endless variety of such activities, or language games, and it is impossible to specify universal rules that capture their essence. As far as language games are concerned, culture and tradition set out in broad terms the rules and values we must follow if we are to understand each other's speech. As native language speakers we acquire these rules as we acquire language and other cultural skills as infants. As adults we just know the rules, and take them for granted in using them with consummate ease. This know-how is a form of tacit knowledge. What can we say about the language games that take place between the two ladies and their doctors?

First, it is clear that they are quite different games, based in different rules, values and words. In broad terms the rules of Mary's game revolve around her use of the word 'depression'. The way she understands this depends in turn on a number of rules about the way we understand ourselves as human beings. For Mary, depression is a deeply personal experience rooted in her physical being as a person, but also affecting her inner view of herself. Her belief that she is depressed and needs tablets is related to the belief that depression is caused by a chemical disturbance in her brain that can be rectified by antidepressant tablets. This is an extraordinarily influential belief in Western culture, one that has grown in strength recently, not just in the specialist world of psychiatry.

Over the last fifteen years, the publication of books like *Listening to Prozac*, *Prozac Nation*, *Prozac Diary* and *Prozac Highway* together with countless magazine, newspaper and television articles suggest that Prozac and the language of neurotransmitters has become a powerful cultural trope through which we make sense of ourselves as human beings[16]. A key feature of this language game is that it sees sadness in terms of depression

arising from a chemical disturbance in an individual's brain, or from faulty thinking processes in an individual's mind. Mary's belief that she is 'useless' as a person is accounted for in terms of faulty cognitions in her mind. CBT 'rectifies' these inner faults so she can think more positively. As language games, both these approaches locate the problem in the depths of the individual's body or mind. Elsewhere, we have argued that the origins of this belief go back to the European Enlightenment[17]. To use the word depression is only meaningful in a culture that historically prioritises the

inner world of an individual subject.

In cultural terms the European Enlightenment does not feature in Fatima's heritage. Not surprisingly she engages in a very different language game to express herself. She speaks about her experiences in terms of her sinking heart and her belief that she is letting her family down. This is a language game in which her relationships, obligations and duties to her family are of paramount importance to her identity. She does not use the word depression for much the same reason that footballers do not use the words 'fifteen love' to describe what happens when they score a goal. There is no place for depression in the language game she engages in to say how she feels. On the other hand in Islamic culture there are concepts that help us to understand her language game. *Huqooq* and *Huqooqul-Ibaad* broadly concern other people's rights, and one's obligations to them, especially family, neighbours and community, as well as their obligations to you. Thus Fatima is engaged in a language game that ties her sense of who she is to her family and community, through her obligations as a good Muslim. This is central to understanding how she talks about her distress. It also means that her faith is vitally important in helping her through her distress. Her moral agency lies right at the heart of this language game. Her identity and value as a human being are set out by the extent to which she is able to do what is considered to be right in the eyes of her faith, her family and her community.

Both women seek help that is consonant with the language they use to talk about their experiences. Mary wants, and gets antidepressants; Fatima wants to be able to meet and pray with Muslim women who face similar moral dilemmas. Both GPs are doing their jobs properly. Both understand their patients' respective cultures, and know what response is required. Both women make a good recovery. There is empirical evidence that good outcomes in mental health are more likely when doctor and patient share common understandings of the problem. Callan and Littlewood[18] interviewed twenty-one White British and sixty three BME patients, asking them about their views about the care they had received, treatment preferences and explanatory models. Patients were much more

likely to express satisfaction with their care where there was concordance between the patient's and psychiatrist's explanatory model. This was independent of the patient's ethnicity.

Conclusions

Living in a multi-cultural world presents us with very special challenges. If we are to have fair and cohesive societies, it is really important that we learn to respect and understand each other's differences. Respecting cultural diversity involves much more than polite attention to dietary habits and religious observance, important though these are. We argue that in mental health care there is much more to respecting cultural diversity than providing interpreters to make sure that people with limited English can communicate effectively with their doctors. This is clearly important in general medical care, but the situation in psychiatry is quite different. This is because the great variety of cultural understandings of distress presents a radical challenge to the commonly held view that psychiatric disorders are universal biological phenomena. Mental health problems are intimately tied to fundamental aspects of our identities, where culture, language, faith and tradition lie right at the heart of our lives.

This has implications for the help offered to those from non-Western cultures who experience distress. It means that we must be aware of the ways in which complex identities shape expectations of help. For example, there is no justification in our argument for the British government's plans to provide cognitive behavioural therapy on a massive scale in the community, much of it in the form of computerised modules, in the belief that this will 'cure' chronic depression and enable long-term unemployed people to get back to work[19]. Equally, it is important to recognise that the complex processes of identity formation and acculturation mean that for some non-Western British citizens individualised forms of 'therapy' such as CBT may be consonant with the way in which they understand sadness.

The anthropologist Arthur Kleinman warns that we commit a serious error (a 'category fallacy') if we assume that the Western concept of 'depression' has the same meaning for non-Western people[20]. Our argument supports this view, and in doing so questions the basis on which authorities like the World Health Organisation plan to implement global programmes to 'conquer' depression in South East Asia, without paying due attention to the great variety of meanings of sadness in the different cultures of the region[21]. Although such programmes are no doubt well intended, respect for cultural diversity in mental health requires an acute sensitivity to the limitations of language. It means that we have to make a deliberate effort to step beyond the confines of our own cultural assumptions to acknowledge the importance of the other's culture in

shaping meaning, and, more important, the responses that meaning expects.

الملخص

إن الإزدياد في التنوع اللغوي والثقافي في المجتمعات المعاصره يطرح تحديات كبيره أمام خدمات الصحه النفسيه عبر العالم. فهل من الممكن العمل بطرائق تحترم الفروقات الثقافيه واللغويه في المجتمعات متعددة الثقافات؟ في هذا البحث نركز على الصعوبات المتأتيه من إستخدام المترجمين في تشخيص الكآبه. ونستخدم هنا تجربه فكريه بسيطه على شكل حوارين لغويين وهميين ومقتضبين من أجل إبراز سمات مهمه في العاب-اللغه ، وهذه فكره أدخلها لودفيك ويتكنشتاين في عمله الحديث "تحريات فلسفيه". التجربه الفكريه المعنيه توجه الانتباه إلى أهمية الثقافه وبيئتها في فهم معنى أقوال الناس حين شعورهم بالحزن. وهذه المسأله ذات أهمية أكبر في تفهم نوعية المساعده التي يتوقعها الناس في مثل هذه الظروف. ويترتب على ذلك تبعات ليس فقط بالنسبة لكيفيه فهم دور المترجمين في المحيط االسريري ولكن بشكل أعم في توجيه الانتباه إلى أهمية إحترام الفهم المتعدد والمختلف للحزن والتعاسه والتي هي سمه بارزه في الثقافات اللاغربيه. ونستنتج في الختام أن محاولات فرض التفسيرات البيو- طبيه الغربيه للسعاده والشقاء على الناس في المجتمعات اللاغربيه هو أمر ليس له أي أساس أخلاقي وعلينا تجنبه.

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Authors

Philip Thomas Honorary Visiting Professor
Social Science and Humanities
University of Bradford

Patrick Bracken Clinical Director and Consultant Psychiatrist
West Cork Mental Health Service
Bantry General Hospital
Bantry
Cork
Republic of Ireland

Mohammad Shabbir Chief Executive Officer
Sharing Voices Bradford
99 Maningham Lane
Bradford BD1 3BN

Salma Yasmeen Deputy Director Community & Partnerships (MHOA)
South London and Maudsley NHS Foundation Trust
Maudsley Hospital
115 Denmark Hill
London SE5 8AZ

Address for Correspondence:
Pogley Barn
9, Top o' th' Town
Heptonstall
Hebden Bridge
West Yorkshire, HX7 7NU
philipfthomas@btinternet.com