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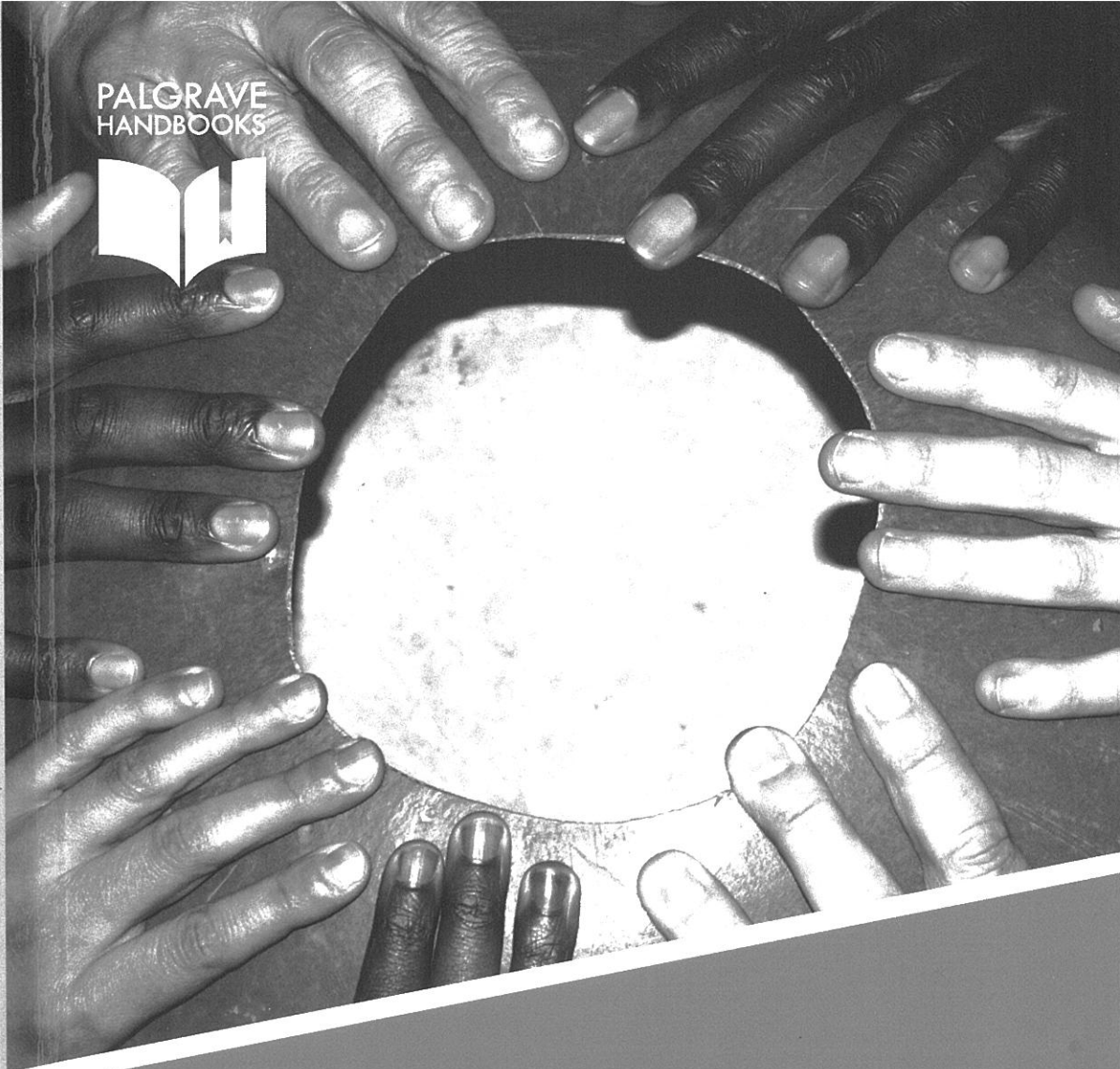
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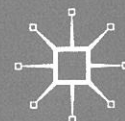
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THE PALGRAVE HANDBOOK OF SOCIOCULTURAL PERSPECTIVES ON GLOBAL MENTAL HEALTH

Edited by
Ross G. White, Sumeet Jain, David M.R. Orr, Ursula M. Read



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Global Mental Health and Psychopharmacology in Precarious Ecologies: Anthropological Considerations for Engagement and Efficacy

Janis H. Jenkins and Ellen Kozelka

Public health campaigns for mental health promote declarations such as “Defeat Depression, Spread Happiness” in India, “Chains Free” in Indonesia, “Silence Is Not Health” in Argentina, or “A Flaw in Chemistry, not Character” in the United States. Within Global Mental Health (GMH), the proclamation of “No health without mental health” (WHO 2005) serves as a rallying point for providers, researchers, and advocacy groups. Calls to “scale up” mental health services in countries designated as low- and middle-income countries (LMICs) have been given priority (Patel et al. 2007; Patel et al. 2009; de Jesus et al. 2009; Eaton et al. 2011). Proponents argue that as matters of urgent need and human rights, there must be greater access to evidence-based treatments, typically with reference to psychopharmaceuticals and psychosocial interventions (Patel 2014). Often only the former is offered, but only the latter is understood to require much adaptation as a matter of cultural validity. While in this chapter we pay particular attention to psychopharmaceuticals, we argue that both types of treatment (and more) require particular cultural consideration of patients and families (Good 2010; Jenkins 2015a; Whyte 1991). The “more” that we have in mind entails stepping beyond the confines of what currently counts as “evidence based” treatment to also take into account both structural and ecological constraints (Farmer 2004; Metzler and Hansen 2014; Jain and Jadhav 2009). Broadening the scope of GMH holds

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“enormous potential to contribute to [these] challenges by exploring cultural feasibility and acceptability of interventions, understanding the impact of health services on the daily lives of providers and patients, and uncovering institutional processes that lead to inadequate and disproportionate commitment to mental health” (Kohrt et al. 2015, p. 341). In this chapter, we identify specific problems with respect to illness experience, cultural interpretation, and local provision of care in relation to psychopharmaceuticals. Further, we suggest strategies to address these difficulties across diverse settings.

Cultural and Political Ecologies of Persons, Families, and Psychotropics

The widespread dispensing of psychotropic medications is typically practised with the idea that these drugs, as bioactive compounds, do not require cultural consideration. Closer inspection shows that this is definitely not the case (Jenkins 2010; Ecks 2013; Ecks and Basu 2009; Basu 2014). First, there can be no doubt that psychopharmaceutical treatment concerns subjective experience and cultural interpretation of illness and healing. This necessitates treatment practices that are guided by a contemporary understanding of culture. What is therefore required is an appreciation of culture in non-reductive terms (Martínez 2000; Jenkins and Barrett 2004; Biehl et al. 2007; Parish 2008). Culture is not a factor, but rather a pervasive process at work in nearly every aspect of mental health and illness, including psychopharmaceuticals. As there are many definitions of culture, it is useful to provide our theoretical formulation of culture with attention to lived experience:

Culture is not a place or a people, not a fixed and coherent set of values, beliefs, or behaviors, but an orientation to being-in-the-world that is dynamically created and re-created in the process of social interaction and historical context. Culture has more to do with human processes of attention, perception, and meaning that shape personal and public spheres in a taken for granted manner. What do we pay attention to and how? What matters, and what does not? (Jenkins 2015a, p. 9)

This approach takes as fundamental the inevitability of multiple, competing perspectives (vs. one-sided accounts of “clinical facts” or “noncompliant patients,” for example). Attention to the multiplicity of perspectives leads to an appreciation of the reality that the experience of giving and taking medication is neither straightforward nor unilateral.

Second, anthropological attention to gender, class, and ethnicity is clearly integral to interpreting these perspectives. For example, appreciating gendered differences in a specific cultural environment is key for communicative clarity in healthcare encounters, as well as aetiology. Worldwide, women and girls disproportionately struggle daily against affronts to psychic integrity that may be conducive of serious conditions such as depression, trauma, and psychosis (Jenkins and DelVecchio Good 2014). These may also alter women’s ability to seek treatment. Likewise, class and socio-economic status are widely recognized as a social determinant of mental health status (WHO 2014). Ethnicity among low-income minorities in countries with vast economic inequality (such as in the United States or China, for example) is marked by a “greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. Living in poverty has the most measurable impact on rates of mental illness. People in the lowest stratum of income, education, and occupation are about two to three times more likely than those in the highest stratum to have a mental disorder” (U.S. Surgeon General 2001; also discussed in Institute of Medicine 2013; Kleinman 1986; How et al. 2011). Understanding the toll that ethnicity and socioeconomic condition, like gender, take on persons’ capability to act, and designing GMH interventions with them in mind, will allow researchers and healthcare workers to provide treatment that persons have the power and desire to access.

Third, in-depth empirical attention to the perspectives of persons and families living with mental illness is a surprisingly neglected area of research (Jenkins and Karno 1992; Hinton et al. 2015); but, available ethnographic accounts show that these persons and their families are grappling with distressing conditions and the complexity of taking medications. They do so, by and large, with little clinical or social support. In both low- and high-resource settings, the taking of psychotropic drugs invariably entails considerable cultural conflict, social stigma, and paradox for persons and their families (Whyte et al. 2002; Jain and Jadhav 2009; Jenkins and Carpenter-Song 2005, 2008; Dumit 2012; Read 2012). Analytical attention to how these cultural forces impact the course and outcome of treatment will be critical to formulating successful GMH interventions.

Finally, patient-provider relationships are often culturally defined by power and embedded in hierarchical social relations of difference. Properly understood, prescribing and taking medication is as a collaborative undertaking that requires negotiation and renegotiation over time. Though not often practised, there are fruitful models to draw upon, such as those pioneered by Partners in Health (Farmer 2015; PIH.org) and the international Hearing Voices Movement (Woods et al. 2013); maximal healthcare efficacy in terms

of psychopharmaceuticals requires maximal collaborative partnership. Yet, in terms of serious mental illness, GMH has little to show that would constitute the fruits of such a collaborative approach. Many GMH care providers and others believe that serious mental illness necessitates the use of psychotropics, and we do not dispute this claim. Yet, for psychopharmacological treatments to remain both valid and efficacious on a global scale, providers must work to transcend the notion that the primary "problem" is patient "compliance" or "adherence." This simplistic view of a patient's relationship with their medication fails to take into account their subjective illness experience, their interpretation of the problem, as well as their own agency and desired outcomes. When "compliance" and "adherence" are the starting points (and often the endpoints) in clinical thinking, it should be little wonder that they are also often the stopping point for patients in resource-poor and affluent settings alike. Without discounting the importance of adherence to psychopharmaceutical regimens, the giving and taking of medication would more productively be conceived as a collaborative process of engagement that only occurs as part of a cooperative effort based on engaged listening.

Thus, our research experience suggests that treatment via psychopharmaceuticals must be approached through a fine-tuned engagement that seeks to take into account (1) the social, cultural, and psychological contexts of mental illness and its treatment, and (2) the ecological features of environments with respect to socioeconomic and political conditions that may predispose persons to mental illness through entrapment in precarious situations. Our argument is that GMH must proceed with an understanding of these dual sets of intersecting factors bound together "extraordinary conditions" of affliction and precarity (Jenkins 2015a). We intend these observations to be a critical locus for making meaningful differences for the course and outcome of mental illnesses worldwide.

The Globalization of Psychopharmaceuticals

The global circulation of the now familiar biomedical narrative of psychotropic drugs as chemical compounds with biological effects has produced widespread cultural knowledge of psychopharmaceuticals and ideas of their efficacy. The extent of this circulation and its particular meaning to patients and families in a given location at a given time, however, should not be presumed to always be straightforward, obvious, or even shared cultural knowledge. While global awareness of the existence and potential utility of psychotropic medications has increased cross-continently, availability and access can be limited or

precluded altogether. While it is obvious that economic and political restrictions represent the first line of separation in determining who receives care, there are other obstacles in relation to mental health policy at international and national levels. Addressing them necessitates consideration of the cultural dynamics of power, access, and privilege.

One significant obstacle is the prevailing presumption that it is inevitable and expected that scarcity of resources impedes access to treatment. Indeed, many clinical sites lack access to even relatively inexpensive WHO-dubbed "essential medicines," let alone more costly psychopharmaceuticals. Kim et al. (2013) have critiqued healthcare policies that take for granted the inevitability of scarcity of resources, particularly in low-income countries. However, even in settings where consistent access to medication exists, the high frequency of discontinuation of medication is noted in both high- and low-income countries (Jenkins 2015a; Lieberman et al. 2005; Read 2012). For example, in the United States, the CATIE study found a 75% discontinuation rate (Lieberman et al. 2005). That study failed to collect empirical data that could account for this finding. Survey data in Ghana reported that in a sample of 1290 patients, 80% stopped taking their medication (Mensah and Yeboah 2003). Reasons for cessation of pharmaceutical regimens frequently involved practical problems of logistics and resources. Yet beyond economic resources to provide concrete forms of treatment, there is a need for greater support from healthcare workers to provide drug information and empathic listening about the shortcomings and difficulties patients and families experience (Brown et al. 1986). Ethnographic research has demonstrated that those afflicted with mental illness and their kin are far from unfamiliar with, or reluctant regarding psychotropic drugs; indeed, they are often aware and highly motivated to seek out such treatments (Basu 2014; Ecks 2013; Duncan 2012; Read 2012; Whyte 1991; Jenkins and Carpenter-Song 2005). In Ghana, for example, not only are people aware of "hospital medicine" (psychopharmaceuticals), they also resort to it frequently, often before seeing a religious healer (Read 2012, p. 441). If the social, cultural, and economic realities of patients with serious mental illness are not given adequate attention, the wellbeing of afflicted individuals and families can neither be understood nor be managed efficaciously with only psychotropics. At this juncture, the locus of failure lies primarily with those of us researching, designing, planning, and clinically implementing mental health programmes around the world. More must be done to ensure that the implementation of the GMH scale-up is done with a fine-tuned engagement towards the culturally, temporally, and geographically dynamic relationships of treatment and contexts of healing.

“Scaling Up”: Problems Spurious and Genuine

Within the field of GMH, there have occasionally been rather startling claims that the overall undertaking is not only fraught but also impossible, since psychiatry really has no effective treatments or culturally valid services to offer (Summerfield 2012). Those who propose this remarkably nihilistic critique of GMH interventions as summarily useless do not appear to have carefully considered the affect that such a claim, if taken seriously, would have on the lives of persons living with serious mental illness and their families. This view appears in part to be an attempt to critique the “Western” biomedical hegemony of GMH and a plea to attend to local and indigenous healing modalities. Such a point is well taken; local understandings of illness and disease most certainly affect the subjective experiences of serious mental illness as well as their course and outcome. However, the presumption that indigenous forms of healing are unconditionally likely to be Rousseauian “natural” wellsprings of resilience requires ethnographic evidence based on patient and family experience in lieu of apparently romantic or naive zeal that the “West” has it all wrong and “The Rest” (must) wistfully have it all right (or at least not that bad). In fact, this view discounts how local social and cultural conceptions of disease may negatively affect course and outcome, that is, social stigma (Jenkins and Carpenter-Song 2005, 2008; Read 2012). Ironically, such critiques of GMH take cultural relativism farther than most contemporary psychiatric anthropologists, in effect using it as a justification to oppose all psychiatric treatment and intervention.

There is a critical need for a deep understanding of the mutual entanglement of culture and psyche in psychiatric care, especially in light of the significant social stigma that mental illness nearly always entails. This requires careful attention to subjective experience and cultural validity of psychiatric nosology and treatment (Kleinman 1988). In fact, the cultural adaptation of interventions is something that anthropologists have argued for since the 1980s, and, thus, does not appear novel. As we have noted, a working understanding of the resonance of psychotropics in a given culture must be grounded in the particular concerns of persons actually living with mental illness (Jenkins 1991, 2015b).

If the validity of psychiatric treatment and intervention with cultural adaptation is accounted for, determining the intended recipients of the scale-up represents another problem for GMH researchers, care providers and advocates. The scale-up aims to make treatment and care for serious mental illness more readily available to those who do not have access; thus, we have reservations with respect to categorizations of those “most” in need based solely on a

country’s designation as low or high income. As described in previous sections, consideration of individual and cultural influences to care for serious mental illness cannot be delimited to LMICs or indigenous peoples living in high-income countries (HICs). All persons exist enmeshed in a sociocultural, political, and economic milieu and this gradient of power greatly affects the dynamics of health and recovery. We believe that it is far too early in the nascent field of GMH to become sedimented in taken-for-granted assumptions and expectations about how to approach relevant fields of application. Patel (2014) draws attention to the well-known problem of the boundaries between the knowledge and practices of “developed” and “developing countries”, pointing to the need for reciprocal and collaborative learning that can address improved mental health worldwide. While this is clear, it has yet to be recognized that such distinctions apply also to the problematic designation of “high-income” countries opposed to “low- and middle-income countries.” GMH must fully recognize and emphasize the reality that such designations appear to subscribe and to succumb to the necessary and justifiable requirement of “scarcity” of attention and resources—so astutely critiqued by Kim et al. (2013)—as justification for triaging in some places (India, sub-Saharan African) and not others. While the reality that there are many settings that require urgent care is daunting, these cannot adequately be identified through current reductive designations of developing or LMICs.

Thus, we challenge the ideas that (1) LMICs and HICs should receive different attention to mental health—all those suffering should have the ability to participate in the healing process with their families and mental health-care providers—and that (2) psychopharmaceutical medications and psychosocial services should be ranked hierarchically, with psychopharmaceuticals eliminating the necessity of psychosocial services. There is a critical need for a spectrum of mental health services in both LMICs and HICs. We object strongly to practices of treatment for serious mental illness based primarily (if not exclusively) on psychopharmaceuticals. The scale-up of GMH services including psychopharmaceutical treatments should be paralleled with an equal scale-up of culturally meaningful psychosocial services, because both are necessary aspects to contribute to the conversation on cure and healing for serious mental illness. Both psychopharmaceuticals and psychosocial services contribute to the wellbeing of the individual with serious mental illness, their subjective experience of social functioning, and their family’s understanding of social functioning. As we shall see in the next sections, what social functioning means varies across space and through time; but, nonetheless, the concerns patients and families put forward are fundamentally about economic and social subsistence. Here, we again challenge the assumption of inherent

global difference, based on socioeconomic status. Through our research and the review of others, we have seen that what patients and families want, be they middle-class US residents, working-class immigrants to the UK, subsistence farmers in Ghana, or political and environmental refugees in Indonesia, resonates with each other. They all want, in their own social, cultural, and economic way (or their kin want them) to function. The global resonance of social functioning brought us to our argument on the fundamental need for attention to subjective experience. It provides us with a window into understanding how social, cultural, and economic differences affect treatment.

Matters of Immediacy: Subjective Experience of Psychopharmacology in Precarious Ecologies

The effectiveness of GMH interventions is contingent on close attention to the complexities of daily experience and the substantial suffering among those who seek treatment for serious mental illness via psychotropic medications. The process of taking psychotropic medication can be bittersweet, since subjective experience can incorporate both treasured relief and troubling social preoccupations, that is, stigma. In the absence of being involved with supportive groups to interpret and to develop strategies to manage these experiences, and in the absence of provider disclosure of the limitations and serious metabolic side effects associated with medications prescribed for serious mental illness, all does not typically go well. In our research experience (with Mexican American, Euro-American, African American, and Native American populations), nothing short of a "cure" is expected and longed for (Jenkins and Carpenter-Song 2005; Jenkins 2015a).

Understanding subjective experience can give incredible insight into why patients decide to take or not take their medication. One of the authors worked with patients of diverse ethnic and socioeconomic backgrounds in the United States using atypical antipsychotics to understand the subjective experience and meaning of treatment for schizophrenia and related mental illnesses. By analysing their subjective experience through narratives, she found that cultural conundrums of "stigma despite recovery" were extremely common, and greatly affected not only their perceptions of treatment, but also their expectations for recovery and healing, in other words their clinical and social outcome (Jenkins and Carpenter-Song 2005). They often reported experiencing long-term treatment with antipsychotics as paradoxical, both medically and socially, by saying things like: "I feel better but not cured" or "I can sleep,

but can't work." Others even reported having to make the choice between being "fat" (drooling or sexually diminished) or being "crazy" (Jenkins and Carpenter-Song 2005). In the context of the United States, where economic independence is paramount to social success, it makes sense that without proper counselling, discussions about treatment, and support groups to manage these conundrums, patients would begin to make choices to improve their social condition, even if that is in detriment of their biomedical condition. In these cases, improving their social condition often meant ceasing their adherence to psychopharmacological regimens. By understanding a person's subjective experience of their illness and society's conception of their condition, we can see just how influential culture can be on course and outcome.

Surprisingly, culture's influence upon the social circumstances surrounding treatment is remarkably similar for patients and families in both HICs and LMICs. Though the dynamic interplay of temporal and geographical factors on culture may result in different understandings of serious mental illness, how it affects the afflicted, and the appropriate course of their treatment, recovery of social functioning remains the ultimate goal. Ursula Read observes that

[c]ampaigns to scale up mental health services in low-income countries emphasize the need to improve access to psychotropic medication as part of effective treatment, yet there is little acknowledgement of the limitations of psychotropic drugs as perceived by those who use them ... whilst medication undeniably brings benefits for many with severe mental illness, such campaigns seem to have glossed over the limitations of psychotropic drugs, particularly antipsychotics, and the ambivalent attitudes they provoke in those who take them. In many cases antipsychotic treatment had been discontinued, even where it had been recognized to have beneficial effects. The failure of antipsychotics to achieve a permanent cure also cast doubt on their efficacy. (2012, pp. 438–439)

As the title of Read's (2012) article poignantly conveys, Ghanaians "want the [psychopharmaceutical] that heals me completely so [the major mental illness] won't come back again." In an earlier study in Ghana, some hospital patients who reported stopping psychotropic medication had sought treatment from a spiritual healer (Mensah and Yeboah 2003). Using an ethnographic methodology, anthropologist Ursula Read (2012) later obtained additional data on the reasons for discontinuation. These included fatigue, drowsiness, weakness, and side effects such as movement disorders and stiffness (Read 2012, p. 439). For many, dissatisfaction with psychopharmaceuticals was rooted in the perception of limited or short-term efficacy and unpleasant side effects.

"While reluctance to take antipsychotics is often attributed to psychopathology or lack of 'insight' ... the subjective experience of unpleasant and dangerous side effects" has "a significant impact on patients' willingness to take them" (Read 2012, p. 439). In Ghana, the short-term benefits (reduction of symptoms) are highly valued; however, they are not enough. For the patients and families Read worked with, a return to social functioning is more valued than symptom reduction. Furthermore, the side effects of antipsychotics conflict with cultural notions of health that emphasize the value of strength (Read 2012, pp. 445–447). In sum, taking medication and feeling better is a complex, nuanced cultural matter.

Similar critiques of care for major mental illnesses, resonate in both HICs and LMICs. This reveals not necessarily that the same solution may be applied globally, but that the same deficiencies of care exist globally in situations of socioeconomic and political precarity, all of which deserve research and clinical attention. So, then, use of psychopharmaceutical treatment is not defined solely by access or awareness. Like their counterparts in the United States, faced with the dilemma of being "fat" or "crazy" Ghanaians must choose between being "noncontributing" or "crazy" (Read 2012). Some persons, when faced with such an impossible cultural choice, in the absence of clinical appreciation and engagement with such difficulties, simply give up, or in biomedical terms, become noncompliant.

Experience-near perspectives must inform critical analyses of psychotropic use in order to demonstrate the numerous quandaries involved in understanding the indeterminate cultural, social, and biological effects of psychotropic drugs (Jenkins 2010). A reduction of psychotic symptoms does not necessarily entail a return to "normal," especially when considering the side effects and chronic nature of treatment. "Since health is aligned with strength, healing is signified by a return to productivity" (Read 2012, p. 447). Thus, when treatment, aimed at health of the individual, interferes with social obligations, the treatment can no longer be considered efficacious. Efficacy gives a drug its value, but that efficacy is social and culturally defined. In Ghana, we see the social lives of medicines (Whyte et al. 2002) at work in both the initial acceptance and later rejection of psychopharmaceuticals. While antipsychotics are highly valued for their sedative nature, after some time, many find the medication "too strong." In part, this may be because mental healthcare workers tend to use high doses, related with the perception of the comparative severity of psychosis in Ghana (Read 2012, pp. 444–445). Yet, this increases the likelihood of side effects, a negative patient reaction and noncompliance. In this case, "noncompliance" reveals the patient's expression of rationality as compared to the mental healthcare workers' (Van der Geest et al. 1996,

pp. 165–166). In some cases and in some places, reduction of symptoms may be enough to continue on the path to recovery. But, the inherent value of symptom reduction through psychopharmaceuticals is in the ability to return to social functioning. When these drugs produce side effects that further decrease the person's ability to participate in society, it is understandable why patients and their families would decide that the best decision would be to stop taking them.

The need for cultural consideration of psychopharmaceuticals extends beyond analytical attention to clinical implementation. Psychosocial and psychopharmaceutical treatments, as a necessarily dual process, need to be explained as both open-ended and unknown in respect to their effects over time. We believe that a fine-tuned engagement with patients and their families is necessary for implementing GMH interventions to prevent the abuse of or improper implementation of the scaling up of GMH. Engaged listening and talking provide critical therapy even though there is the cultural conception in many societies that this form of therapy cannot or does not have the same efficacy as psychopharmaceuticals. The expectation for immediate and sustained cure is unlikely to be met in the case of serious and persistent mental illness. Nevertheless, expectation for incremental improvement over time can be understood as integral to the healing process. Thus, when Akosua, a Ghanaian patient on antipsychotics, says, "I want the [pill] that will heal me completely so it won't come back again" (Read 2012, p. 447), we can understand what type of cure she is looking for, which is linked to her sociocultural conceptions of health. In this case, the collaboratively based "engaged listening" and conversation would allow mental healthcare providers to begin the conversation on the open-endedness of current treatments for serious and persistent mental illness. By more accurately representing the timeframe of treatment as uncertain and open-ended, this may help address issues of pharmaceutical adherence and continuation of care.

Further, the evaluation of GMH interventions must be conducted with a fine-tuned engagement to culture. When prescribing antipsychotics, mental health workers need to engage in dialogue with the persons seeking treatment. We concur with Read (2012) that mental health workers need to be frank about the limits of antipsychotics; they must discuss openly the true medical and social expectations that can be and often are associated with the use of psychopharmaceuticals. Evaluation of interventions must ensure that these conversations are occurring and patients and families are receiving the support they need psychopharmacologically, socially, politically, and economically. In other words, the "scaling up of psychiatry in low-income countries" should be carefully monitored, lest it actually become a scaling down to

“administrative psychiatry whose primary objective is the prescription of psychotropic drugs and the reduction of symptoms, rather than addressing the social or psychological factors which may contribute to mental breakdown and recovery” (Read 2012, p. 441). The aim of the scale-up of psychiatric services should be to ensure the best possible treatment for mental illness; then, projects to implement that care must provide not just an initial investment but ongoing training, monitoring, and accountability. This includes both medicinal treatment and psychosocial treatment. In this way, patients and their families can better understand their condition, what current treatment can actually provide, and how they all can participate in the healing process. In the next section, we will explore how this treatment extends far beyond prescribing psychotropic drugs and into the arenas of social, economic, and political reform.

Advocating for Recovery: Development and Delivery of Care

Anthropologically, it is clear that the complex psychocultural and sociopolitical dimensions of the subjective experience of medication and treatment continue to require close attention. There is a crucial need for engaged listening to the fears, hopes, and lamentations over cures that are only partial or ephemeral. The delivery of healthcare is one of the primary aspects of patient experience of psychotropic medication that must be considered; it can and does have a foundational influence on how patients experience their medication. This has a drastic impact not only on their subjective experience but also on course, outcome, and compliance. Here we will illustrate the need for both an individual and collective understanding of the treatment environment and how open dialogue is the best method to achieve this at the patient-provider exchange.

For example, post-traumatic stress disorder (PTSD) has always been a source of controversy. As Good et al. (2014, p. 5) argue, there is good reason to investigate and critique the emergence as well as the expansion of PTSD as a clinical category. In anthropological literature, this critique has often been directed at the standardization or “professionalization of social suffering” (Kleinman and Kleinman 1997; Breslau 2004) but it has also addressed the rhetoric of “humanitarian interventions” which use diagnoses of trauma as vehicles for alternative modes of sovereignty to further political ends (Good et al. 2014, p. 5; Kienzler and Pedersen 2012). Jenkins (1991) further argues that overuse of medical categories like PTSD can lead to a neglect of the social

and political roots of the causes of PTSD. Thus, there are indeed problems, both spurious and genuine, to the expansion of PTSD as a category and the worldwide increase in diagnosis. However, that does not make the suffering currently clustered under the diagnostic category PTSD any less real. What these scholars criticize or challenge, we argue, is not that suffering can be caused by particular events, or even series of events, but that some physicians and social policy makers can become slaves to the diagnostic criteria, using statistics generated from them to further political or economic goals completely divorced from the suffering each criterion and its number represents. Jenkins (1991) has argued for the opening up of the category PTSD. Thus a legitimate critique of PTSD is focused not on whether or not the illness exists, but how others, particularly aid workers, GMH interventionists and researchers who may not be based in or particularly familiar with the country in question, respond to it and impact the healing process. These arguments echo our call for the effects of environment on mental health to be taken seriously.

This is not to deny that some scholars discount PTSD as a legitimate diagnosis. Some have referred to it as a pseudo-condition that both pathologizes entire populations and represents a new form of colonialism (Summerfield 2004; Pupavac 2002). However, this narrow view does not follow from the justifiable critiques offered by others (Kleinman and Kleinman 1997; Jenkins 1991; Breslau 2004; Good et al. 2014). Referring to PTSD as a pseudo-condition could be what Read (2012) described as a miscommunication; yet the GMH interventions that would result from this critique would have a significant impact on what kind of care would be made available and what would not, because it neglects to take into account the larger socioeconomic and political influences on serious mental illness. Further, this argument’s foundational claim that psychotropics are unwillingly pushed on “non-Western” populations is a direct contradiction to what Read discovered in Ghana or Good et al. (2014) discovered in Indonesia, both major recipients of international aid. There are certainly serious issues with the way interventions using psychopharmacology are implemented in Ghana and other places, but this is not because the illness of psychosis is not “real” or not socially recognized. It is because there has been structural and individual miscommunication between providers and the patients and families seeking treatment.

So what are we debating in terms of major mental illness? Is PTSD or any diagnostic tool really good enough to discuss serious mental illnesses as categories? If symptom clusters are found around the globe, then is the real debate here epistemological? This we argue can be addressed in terms of the methods used for scaling up GMH. We and many other anthropologically oriented GMH researchers argue for mixed methods in interventions, evaluations and

education. For example, Good et al. (2014) collaborative efforts with the International Organization for Migration (IOM) in Indonesia entailed the development of mental health outreach teams, which was staffed by Acehese general practitioners and nurses (Good et al. 2014). The Harvard Team's role in the project was not intervention but evaluation. Their supporting role as researchers listening seriously to the conditions of the Indonesian people in tandem with their Indonesian colleagues allowed them to help advocate for the care people asked for. Thus, fine-tuned engagement towards the cultural manifestations of trauma and suffering and collaborative approach to researching, implementing, and evaluating allowed the national and international team tasked with responding to Indonesia's crisis to begin responding to the mental health needs of the Acehese people and advocate for the political, economic, and social issues to be factored into it.

Culture, psyche, and biology are all integral to understanding the complex processes and pathologies of mental illness. The biological aspects of an illness cannot be understood and thus treated properly if the larger socioeconomic and political environment as well as individual, subjective experiences are not equally considered. Like the moving parts of a conversation, attention and awareness must be given to all three, if not more. We recognize that different researchers in different fields will focus in on or find certain parts of that conversation more interesting. Psychiatrists may be more interested in the changing levels of serotonin while a patient is on SSRIs, while psychiatric anthropologists may be more interested in learning about the embodied experience of consuming the SSRIs. While extremely different in focus, when combined, they provide a clearer picture, overall, of what psychotropics do, how they are experienced, and what factors influence persons to take or not to take psychopharmaceuticals. The embodiment of culture through the use of psychotropics, has been a focus of this paper, but it is but one of the many moving parts that enter into the conversation on GMH. Here, we have argued that open dialogue and interdisciplinary work via a fine-tuned engagement with the cultural context should be the foundation of GMH interventions and evaluation.

Conclusion

This chapter has primarily discussed the problems of efficacy and validity associated with mental health services in relations to pharmacological treatments for serious mental illness. We have argued that services require cultural validity contingent on the specific environment of the planned intervention.

In order to create both valid and efficacious interventions, GMH researchers, practitioners, and advocates must recognize that (1) psychopharmacological attention and treatment can be successful only when treated in equal tandem with the psychosocial interventions; (2) patient and family illness experience, interpretation of the problem, and desired outcomes must be understood; (3) local provision of care must be collaborative, which in the case of psychopharmacology requires attention to the first two points that we have argued as matters of engaged listening; (4) what "functional" means varies globally and temporally, but it drastically impacts the understandings of our second point, and thus they must be taken into consideration when formulating an intervention; (5) the meaning of treatment and healing modalities entail subjectively experienced paradoxes of taking medications that can only be understood when persons living with mental illness are engaged in the provision of services through collaborative listening by those providing them. Thus, there are many moving and intertwined parts involved in the conversations surrounding the scaling-up of GMH interventions. A critical first step in this direction is engaged listening, collaboration, and an informed understanding of the particular circumstances of the environment in which particular interventions are directed. We have argued that to be effective, GMH must proceed with an understanding of these sets of intersecting factors as "extraordinary conditions" (Jenkins 2015a). We are convinced that attention to this critical locus is necessary to make meaningful differences for the course and outcome of mental illnesses worldwide.

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9

Commentary on 'Mental Health Across the Globe: Conceptual Perspectives from Social Science and the Humanities' Section

Duncan Pedersen

This part of the handbook deals with transdisciplinary perspectives from the social sciences and humanities on some of the most crucial issues of the Global Mental Health (GMH) agenda. The various chapters take us on a captivating disciplinary tour across central GMH notions such as medicalization of distress, recovery from severe mental illness, space and mental disorders, culture and treatment outcomes, positive mental health and happiness, cultural idioms of distress and psychiatric classifications.

Miller (chapter 5) tackles issues of colonial and postcolonial psychiatry in the context of Africa and postcolonial India; Aldersey and collaborators examine the notion of 'recovery' from severe mental illness, using a comparative perspective in three different cultural contexts: the USA, New Zealand and Nigeria; McGeachan and Philo (chapter 2) posit a geographically informed analysis of mental health and illness and its spatial distribution, examining a wide range of concepts going from spatial epidemiology to therapeutic landscapes. Harding (chapter 4) contributes from a historical perspective to explain how modern concepts of mental health and illness are constructed in Japan and India, through a dialogue among ancient healing traditions and the legacy of colonial and postcolonial systems of mental health care in successive encounters with the West. Jenkins and Kozelka (chapter 8) show us, from an ethnographic perspective, how persons and families living with mental illness are confronted with hard decisions when taking psychotropic drugs, and

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