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Intimate and Social Spheres of Mental Illness

ENTERING THE RECEPTION AREA, I moved quickly to shake off the sub-freezing wind chill of late winter. The glint of New Mexican sunlight shone through the windows of the pueblo-style residential treatment cottage where I met Taciana. This was her first psychiatric hospitalization, and she had arrived the previous week. Petite and soft-spoken, she seemed younger than her fourteen years of age. She had agreed to meet with me, and I began by letting her know that I was not part of the treatment team but part of a research team trying to learn how young people come to the hospital. After giving her consent to participate in the study, she launched immediately into a forceful narrative: "I am Zuni. . . . I came here because bad things happened to me and some people told me I could come here to rest. People could take care of me. This is my first time coming here, or in trying to commit suicide. I hate myself. Because I hear voices, like voices telling me what to do, or 'hang yourself, do it, become like one of us.'"

She explained that hanging herself seemed like it was "worth it" and that she had no idea how long she'd been hanging before her father found her. He

told her that she needed help. She agreed and subsequently told her school counselor that she wanted help because she was "having trouble dealing with anger." The counselor responded by saying that "there were some real nice people at a hospital who can help." She underscored that she had "volunteered" to come to the hospital "for depression" and because "I was dealing with a lot of things." This included the recent death of her grandfather. There seemed no point in going to school any longer. She smoked marijuana, drank alcohol, and used other drugs with greater frequency. She sought out her oldest brother. He told her that she had been "hanging around the wrong people," "getting angry," and needed to follow the light "to get out of your trouble." Looking down at the floor, she continued with how, at an early age, social workers had removed her from her home because, while there was always plenty of alcohol, drugs, and fighting, there was little food or care. Looking up, she said that coming to the hospital had really helped her and that she was glad she came. Without interview questions or prompting, she continued her story of a young life ravaged by assaults on her bodily and psychic integrity.[1]

The circumstances of Taciana's life and suicide attempt were not uncommon as precipitating events of admission to the hospital among participants in an ethnographic study of children living on the edge of experience under conditions of structural violence. This particular study, as with several I have conducted as a medical anthropologist, was an endeavor that brought together a research team of medical anthropologists, psychiatrists, and psychologists working collaboratively with a clinical team of providers in a children's psychiatric hospital in New Mexico. The state ranks extremely high in child poverty as well as in ethnic diversity (48.5 percent Hispanic/Latinx and 10.5 percent Native American/First Nation peoples).[2] Poverty and fragmentation of kin networks mark the lived experience of many youth living under conditions such as Taciana's.

In this chapter, I reflect on the needs, capacities, and conditions surrounding mental illness. As Taciana's narrative makes clear, this endeavor requires attention to intersecting spheres. First is the primacy and immediacy of experience as the starting point for moral modes of inquiry.[3] For Taciana, this begins with her Zuni identity, self-hate, bereavement, anger, and drug use. Second is attention to cultural meaning and expression. These are essential to avoiding the epistemological error of "category fallacy," wherein psychiatric diagnostic categories can be applied in the absence of cultural validity.[4] While Taciana reported that she came to the hospital "for depression," she makes clear that far more is going on in her social world in relation to danger

and uncertainty and her experience of what really matters.[5] Third is the palpable centrality of suffering in human lives that can conduce to conditions of mental illness. Taciana felt lost and in anguish, struggling to figure out how to be, or not be, in this world. Across these spheres of experience, meaning, and suffering, I have identified struggle as a central process of mental health and illness. This point is vital since many approaches in cultural anthropology, and medical anthropology, can appear to be tone-deaf to the considerable agency and effort of people with whom they work and about whom they write. Attention to struggle across these spheres can also emphasize the high human stakes involved in their intersection, as well as their relevance for the movement to scale up global mental health care. Accordingly, I conclude this essay with a reflection on the importance of ethnographic approaches as foundational for this emerging field.

Ethnographic Foundations and Extraordinary Conditions

Thinking about intimate and social spheres of mental illness ideally entails multiple vantage points from health sciences and social sciences to bring together what I think of as sets of "extraordinary conditions."[6] Common use of the term *extraordinary* implies circumstances or capabilities that are exceptional or unusual. This makes sense in certain contexts, of course, but is not my concern. Condensed into my use of this phrase is a double meaning referring to (1) personal experiences of bodily and psychic alteration that are culturally diagnosed as various forms of serious mental illness; and (2) social conditions of precarity as recurring or sustained forces of violence, poverty, misogyny, racism, abuse, or neglect.[7] These dual sets of extraordinary conditions are reciprocally produced. They might come to feel "ordinary" in the sense of becoming routinized, recurrent, or expectable. However, as experiential modes of suffering and conditions of social pathology, they are not in this formulation properly regarded as either unusual or normative but instead as sites for engaged listening, care, and social change.[8]

To illustrate such extraordinary conditions, I draw on my collaborative research on culture and mental health. The studies have focused on key issues in the field, including the course and outcome of schizophrenia in kin-based households; psychic trauma and depression among immigrants, migrants, and refugees fleeing political violence; clinical ethnographies of inpatient and outpatient settings; the mental health of children and families marked by neighborhood and drug-related violence; and carceral immigration policies as a sociopolitical determinant of mental health. These studies are

situated within the now substantial body of work by medical anthropologists investigating multiple forms of affliction such as depression, schizophrenia, bipolar, anxiety, neurodegenerative, substance misuse, and eating disorders, yielding fine-grained ethnographic views of psychopharmacology, biomedical technologies, (un)natural disasters, institutions and incarceration, and transnational forces.[9]

The background for the ethnographic study of mental illness concerns an enduring problem within anthropology, psychiatry, and the philosophy of science: how to conceptualize the normal and abnormal, the healthy and the pathological. Early twentieth-century challenges by anthropologists and psychiatrists who were ethnographically and psychologically minded went against the grain of conventional thinking about mental illness. The substantial diversity of cultural and psychological experience was identified through comparative method, as deployed in Ruth Benedict's analysis of the unstable boundary between the normal and the abnormal.[10] Writing against racialized and sexist thinking that has institutionalized inequality, her attention was trained on the multiplicities of experience and identity not as aberrant deviations but as existing across a cultural range of gendered and sexual being. The psychiatrist Harry Stack Sullivan insisted on the "normality" of schizophrenia. Arguing from a continuous model for conceptualization, Sullivan maintained there was little difference between the slip of the tongue or inability to recall the name of a close colleague and the fixed delusion that one was Napoleon III. The anthropological linguist and psychological anthropologist Edward Sapir was resolute that "cultural anthropology, properly understood, has the healthiest of all scepticisms about the validity of the concept of 'normal behavior'" and is "valuable because it is constantly rediscovering the normal."[11] A series of ethnographic-psychiatric projects directed toward dismantling dire limitations of European thinking about mental illness ensued, including works by Gregory Bateson, Cora Du Bois, George Devereux; A. Irving Hallowell, and Abram Kardiner.[12] This body of work paralleled formulations of philosophers of science who argued for separation of the "abnormal" and the "normal" as untenable.[13] Beginning at the end of the 1970s, a series of publications by Arthur Kleinman both consolidated these advances and launched a paradigm shift, renovating the field of transcultural psychiatry and energizing a new generation of medical anthropologists.[14] This transformation endures as straightforward and incisive and undergirds which questions are asked and which are overlooked in anthropology.

The Primacy of Experience

The theoretical move to foreground experience *qua* experience is vital within anthropology, since the very notion has generally been missed or ruled as outside the parameters of the field.[15] In the 1980s, explicit anthropological foray into the question of experience was framed as likely peculiar to modernity and of limited application. Further, experience was defined incongruously as "cultural performance and display."[16] Thus, this curdled into pretty much the same old thing: experience is a suspect notion.

Kleinman's case for the primacy of experience as the *starting point* of anthropological investigation remains innovative since attention within medical anthropology has largely been trained on critiques of biomedical reductionism.[17] This merely supplants biomedical reductionism with cultural reductionism:

The [anthropologists'] interpretation of some person's or group's suffering as the reproduction of oppressive relationships of production, or the symbolization of dynamic conflicts in the interior of the self, or as resistance to authority, is a transformation of everyday experience of the same order as those pathologizing reconstructions within biomedicine. Nor is it morally superior to anthropologize distress, rather than to medicalize it. What is lost in biomedical renditions—the complexity, uncertainty and ordinariness of some man or woman's unified world of experience—is also missing when illness is reinterpreted as social role, social strategy, or social symbol ... anything *but* human experience.[18]

Arthur Kleinman and Joan Kleinman hastened to point out that human experience can never be acultural, ahistorical, or understood apart from social power. The principal problem of experience-distant anthropological interpretation is the risk of "delegitimating their subject matter's human conditions. The anthropologist thereby constitutes a false subject; she can engage in a professional discourse every bit as dehumanizing as that of colleagues who unreflectively draw upon the tropes of biomedicine or behaviorism to create their subject matter. Ethnography does participate in this professional transformation of an experience-rich and near human subject into a dehumanized object, a caricature of experience."[19]

The value of an epistemological weighting of experience for ethnographic study of mental illness can be demonstrated by pointing to key issues concerning psychosis. First is how a concentration on experience sheds light on models of the normal and the pathological as continuous phenomena.[20] This has been demonstrated for an understanding of schizophrenia in an in-

terdisciplinary volume edited by me and the late psychiatrist-anthropologist Robert Barrett.[21] In that book, contributors bid adieu to approaches derived solely from descriptive psychopathology and classificatory psychiatry in favor of interrogating the nexus of subjectivity, culture, and psychosis through multiple ethnographic filters. Second, the subjective experiences of people diagnosed with schizophrenia appear as matters of bodily alteration and social disruption.[22] These include alterations in—but not the negation of—embodied selves, emotional experience, sexual desire and identity, cultural interpretation, and social relations as fundamental human processes.[23]

In these two respects, using an experience-near ethnographic approach with people and kin who actually live with conditions of mental illness in "real world," everyday environments brings into view what I have argued is the sine qua non of an anthropological understanding of mental illness: people living "with" conditions of serious mental illness differ little in fundamental human capacities from those "without" mental illness.[24] Yet people with mental illness have curiously been regarded as somehow lacking culture and lacking in emotion or social attachments and, at best, are treated as footnotes for anthropological theorizing.[25] Such sequestration not only "does damage to the integrity of non-ordinary subjects but also leads to intellectual peril for scholarly of fields that indulge in it."[26]

When we compare different kinds of disorders—say, depression and schizophrenia in my studies—an ethnographic surprise emerges in relation to the interpretation of lived experience. What appears ineffable, yet subjectively perceptible, is an alteration of what can be termed the *rhythm of life*. Often there appeared to be a moral struggle either to maintain or find anew one's sense of rhythm or involvement in the flow of everyday activities. Patients articulated their suffering over having lost or been thwarted from ever finding a sense of rhythm, given the persistent or recurring context of major mental disorder.[27]

Without devaluing the utility of identifying symptoms and making psychiatric diagnoses, my ethnographic studies of the experience of and response to mental illness reveal not the centrality of symptoms but, instead the centrality of processes of *struggle* against this disruption of rhythm. Struggle is intrinsic and is seldom eclipsed in the often weighty and intrepid social engagement with living, working, and caring for others despite an onslaught of debilitating and frightening experiences of mental affliction. In this respect, my research suggests that the lived experience of mental illness is described more precisely not by the conceptual pairing of vulnerability and resilience but, rather, by replacing that pairing with the more active processes of precarity and struggle.

The ethnographic value of studying experience looms large also for the intersubjective specification of alterity, the cultural delineation of those with and without mental illness as "us" and "them." As cultural and political processes, otherizing often renders subjects not fully human. The construction can be observed in the difference between experience-distant and first-person accounts of mental illness, as well as everyday discourse on perceived kinds of people and nonpeople. This occurs across nearly all social sectors, including academic professions such as anthropology and psychiatry.

I vividly recall speaking with an eminent psychiatrist who specializes in schizophrenia one Sunday morning after brunch in New York City. The psychiatrist was a consultant on one of my studies funded by the National Institute of Mental Health, and we had spent two hours going over the study design and procedures. In a relaxed moment while saying goodbye on the street as I caught a cab, he confided, "Really, Jan, I'll be very surprised if you find anything like you seem to be looking for in those people, certainly nothing of a real psychological life. I've never seen it." I was shocked: how could someone who worked so closely with people not know more about experiential realities? Two decades since, having heard the same refrain in different ways across many quarters, professional and nonprofessional alike, the surprise has long since worn off. The shock, however, has not.

On the basis of decades of ethnographic and longitudinal studies that I have collaboratively undertaken, there is no empirical or ethical basis for the otherizing of people living with conditions of mental illness. Such otherizing takes place because mental illness concerns fundamental human processes that are ignored, denied, or downgraded by people who imagine themselves as different from, and morally superior to, their objects of derision. Modulations in the rhythm of life and engagement in struggle are experienced by both the afflicted and unafflicted. Thus, distinctions—explicit and implicit—between "us" and "them" are untenable.[28] Moving away from pathologizing categories of incapacity and inferiority and toward capacity and similarity is important. Sebastián, one of the many hundreds of persons with whom I have worked, put it well when he told me, "I'm just like everyone else, except I hear voices."[29]

Cultural Validity: Traversing the Category Fallacy

Working to develop an alternative to decades of universalist assumptions in psychiatry, Kleinman identified the practice of making clinical diagnoses in the absence of cultural validity as predicated on a "category fallacy."[30] The

observation and interpretation of the behavior and expression of symptoms is problematic in the absence of considering culturally communicative meanings. The risk is that reliance on standardized diagnostic criteria can fail to recognize substantial cultural variation in the expression of symptoms in relation to gender, social class, ethnic identification, linguistic and paralinguistic expression, and somatic modes of attention. The notion of "somatic modes of attention," formulated by Thomas Csordas, draws attention to the "culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others."[31] Ethnographic examples include somatization among Chinese patients, Fijian bodily experience not in relation to the individual self but more as matters of community practice, and Salvadoran embodiment of fear and anxiety experienced as intense heat (*calor*) that pervades the body.[32] Neglecting such culturally constituted phenomena can lead to misdiagnoses or improper treatment. For instance, in the Salvadoran case, *calor* has been diagnosed in emergency room settings as acute psychosis or panic attacks for which psychiatric hospitalization is required. A core problem remains one of ethnocentrism built into diagnostic categories developed for European or Euro-American populations and not infrequently skewed toward men of middle-class backgrounds. Thus, the problem concerns the question of what can validly constitute the "normative baseline" and how, when misapplied, the description and classification of categories of disorder (psychotic, mood, anxiety, etc.) can be misleading or useless.

While for research purposes reliable psychiatric diagnostic categories can be useful as starting point for identifying and sorting kinds of illness, in ethnographic work they can never be an end point of inquiry.[33] To return to the case vignette of Taciana, there appears to be clinical utility for the diagnostic category of depression that she herself endorsed. But as we saw from her perspective, far more was going on in relation to "bad things" happening to her. In the New Mexican study, we used the child version of the Structured Clinical Interview for the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), or the KID-SCID, administered by a clinical research team member, to ascertain research diagnostic criteria (versus clinically deployed diagnoses).[34] The child psychiatrist working with our team is highly experienced and has worked with Native Americans for decades. Thus, he is highly attuned to culturally and ecologically specific conditions of life in the region. Results show that Taciana met research diagnostic criteria for several diagnoses: attention-deficit/hyperactivity disorder (ADHD), with culturally specific qualifications and equivocations; major depressive

disorder (with mood concurrent psychotic features); separation anxiety disorder; posttraumatic stress disorder; alcohol dependence; drug dependence (several, including cannabis, cocaine, inhalants); and subthreshold bulimia nervosa. This is a dizzying array of diagnoses that are unstable not only as clinical categories but also as a function of age. Clinicians generally agree that it is difficult to diagnose children and young adolescents in light of developmental processes of change. Yet according to SCID research diagnostic criteria, which entail high levels of symptom severity, nearly all in the study met criteria for two to three psychiatric diagnoses. This particular research project has led me to look askance at psychiatric diagnoses in the case of children living under conditions of structural violence. However, from Taciana's perspective it seemed that she herself considered depression, trauma, drugs, and parental abandonment as highly relevant to her situation.

As she insisted, however, this was not the whole story. She simultaneously considered that she needed protection from the "bad things" that had happened to her. The matter also entails the question of temporal validity insofar as this was her interpretation at the outset of her first psychiatric hospitalization. Two months after being discharged from what our research team and the research participants regard as a relatively high-quality care facility, the situation had become even more complex and layered. Taciana's narrative departed sharply from that introduced above ("I am Zuni.... I came here because bad things happened to me") to a neoliberal rhetoric of the for-profit behavioral-health residential facility to which she was transferred: "I'm here because I fucked up my life. I did it to myself. I can't really do anything right. I need to use my coping skills." Yet Taciana combined this institutional concentration on her wrongdoing with a sustained conviction that Zuni ritual healing (dancers) and religious power (corn pollen) were effective in "sucking these little bad things outta you" and "taking the stress, anger, and depression out of one's system." She clung to her corn, which she felt had protected her since she was a baby. Yet in the pauses and silences in the telling of that narrative, there was a palpable intersubjective sense of confusion of the unsaid: if the corn was protective, if the gods were powerful, how could she feel so terribly lost and abandoned in such an awful place with so little care?

Thus, cultural definitions of and explanations for mental illness can shape experience as matters of internalization, acceptance, or rejection, varying over time and across settings. While the change in Taciana's narrative from one based on cultural identity and harm by others to self-accusation and

individualized responsibility is disturbing, caution should be exercised by researchers and clinicians alike before discarding *psychiatric diagnoses* as irrelevant or harmful. Important to note in this instance is that the changed narrative is focused not on a cultural diagnostic category (e.g., depression) but, instead, on ethnopsychologically imagined individual flaws deployed by low-paid staff with little professional training who work in residential facilities largely in a carceral capacity. The attribution of individual moral blame would be staunchly denied by professional psychiatrists or clinical psychologists, who instead endorse a disease model. For them, the question of individual characteristics and responsibility is present, albeit in subtler and more deeply seated forms.[35]

Historically, there is ample evidence of the harm that can come from thinking psychiatric diagnoses apply to some people and not others. This is the case in racialized accounts of mental illness crafted through colonial psychiatry. Working for the British government in Kenya, for example, the physician J. C. Carothers made sweeping claims that "African" peoples were innately lacking in moral sensibilities of guilt, shame, and responsibility. This claim was used to promote the a priori presumption that "Africans" could not, and therefore did not, suffer from depression.[36] Working ethnographically during that same period, the anthropologist-psychiatrist M. J. Field drew an entirely different conclusion based on detailed ethnographic and clinical materials. Field reported major depression to be common in rural Ghana, with symptoms remarkably similar to those she had observed clinically in London. Through meticulous case studies documenting sentiments of guilt and clinical syndromes of depression, Field established not only that depression was common in rural Ghana, but also that it was particularly notable among women of seniority who had lost social power in the context of patriarchal privilege.[37]

It is difficult to imagine how flawed thinking about depression would ever have been significantly challenged in the absence of ethnographic studies. While there is a growing recognition of somatic complaints as possibly indicative of depression in some primary care settings, everyday clinical discourse on types of depression as "sophisticated" (psychological and verbal emotional presentations) or "unsophisticated" (somatic and bodily presentations) has hardly disappeared.[38] Kleinman's works from Taiwan and China demonstrated that depression is experienced and expressed primarily not as dysphoric affect but, rather, in somatic terms that is not reducible to differences in formal education or economic status.[39] Yet somatic experience and expression of depression are in varying degrees prevalent worldwide, including in much of the United States.

Centrality of Suffering as Existential and Social Experience

Within medical anthropology, a research focus on suffering mirrors the human condition broadly and specifically under duress. The identification of social and personal suffering in Kleinman's formulation entails the recognition of "suffering [as] one of the existential grounds of human experience; it is a defining quality, a limiting experience in human conditions." This identification is simultaneously qualified with a caution against "essentializing, naturalizing, or sentimentalizing suffering in its many forms, both extreme and ordinary."[40] Moreover, the invocation of "suffering" can be misdirected through popular appropriations or as an objectification of people.

Perhaps unsurprisingly, given the prominence of scholarship in medical anthropology concerned with pain, suffering, and affliction as critical domains of anthropological analysis, this area has been critiqued in some quarters as a delimited pursuit.[41] Such is the case with Joel Robbins's infelicitous characterization of anthropological studies that address suffering as the discursive replacement of the historically fraught "savage slot" with that of the "suffering slot."[42] This rendering of medical anthropological scholarship is destitute by virtue of imprecision and conflation, as "a problematic instance of equating an anthropological focus on the various forms of human suffering with the erstwhile anthropological interest in conceptions of the savage. Such a caricature erroneously compares a mode of experience (suffering) with a category of being (savagery) and confuses description (of savagery) with critique (of suffering)."[43]

Robbins, arguing that medical anthropology is dominated by a concentration on affliction and suffering, provides a wholesale characterization of the field as a largely sentimental pursuit, leading us astray from the rightful direction for anthropology. Without irony, there is a call for a "return" to moral theory and philosophy in pursuit of an "anthropology of the good."[44]

Given the legacy of inattention to mental illness that has now been supplanted by a considerable body of work by medical anthropologists, a call for such a "return" appears to be a move to delegitimize people who live with such conditions and render them peripheral to the cultural theorizing of society, institutions, and human value. Quite the opposite has been true for seminal thinkers in the history of medicine who have examined the broader relevance of mental illness.[45] The intersection of society, institutions, and madness is well known in the work of Michel Foucault, and it is particularly compelling in his essay on the interconnections of passion, delirium, and madness.[46] Within medical anthropology, this brings to mind the now classic

volume on depression as emotion and disorder edited by Kleinman and Byron Good that collected ethnographic and clinical studies bridging the fields of ethnopsychology and cross-cultural psychiatry.[47] Studies of psychological trauma have also drawn on historical and cultural treatments of emotion and illness, such as the publication of "Psychological Automatism" in 1889 in which Pierre Janet formulated trauma in the wake of an event experienced as "vehement emotion" followed by dissociation or attachment to the trauma such that people cannot easily go on with their lives.[48] Treatments for trauma in specific contexts of political violence and warfare have also concerned the interface of or continuum between psychic disease processes and dysphoric affects.[49]

Thus, however a political academic move to downgrade the anthropological study of suffering is intended, it is offensive by distorting not only the lives of many worldwide but also the wealth of ethnographic works that critically examine the lifeworlds of people, communities, and institutions under geopolitical forces of repression. A commentary by Seth Holmes on this most recent iteration of cultural reductionism identifies it as an "ethnographic refusal in which anthropology students are counseled or ridiculed away from theorizing and representing realities their research participants may experience and narrate as suffering and violence."[50] In Holmes's ethnographic case, as well as in many of my studies, writing and speaking about suffering is not the idiom of the anthropologist but precisely the language of the people with whom we live and work. The denial of suffering is just that: denial. And, perhaps, as Holmes suggests, ethnographic refusal. Anything *other than* experience.

Global Mental Health and Medical Anthropology:
Possibilities and Impediments

The field of Global Mental Health (GMH) emerged with the battle cry, "No health without mental health."[51] The move to prioritize mental health seeks to balance the great disparity of attention and funding for infectious and other diseases at the expense of what are classified as "noncommunicable" diseases.[52] Typically, the disproportionate emphasis on infectious disease is presumed to be justified in terms of grave risk to mortality and biosecurity. This is problematic, however, in light of the high proportion of populations living with disabilities associated with mental disorders. Further, when comparing the general population and those with mental disorders through meta-analysis models, the risk of mortality is significantly higher among people with mental disorder. The median number of years of life lost is estimated at ten years worldwide, with eight million (14.3 percent) deaths attributable to mental disorders annually.[53]

For the development of a theoretical and methodological foundation for the field of GMH, there is a prodigious body of interdisciplinary work produced by cultural psychiatrists, by medical anthropologists, and in allied fields. However, this would hardly be observable from review of GMH publications of the past two decades. Currently, there appears to be a lack of either familiarity with or serious interest in integration of anthropologically infused thinking within the GMH enterprise. This circumstance evokes a distinct sense of déjà vu with respect to what transpired in the wake of the International Pilot Studies of Schizophrenia (IPSS) conducted by the World Health Organization (WHO) in the 1970s.[54] An ambitious study across five continents complemented by additional longitudinal follow-up studies, the IPSS released initial findings for transnational differences in course and outcome that remain robust.[55] The IPSS design was conceived and carried out in the absence of collaboration with anthropologists. This oversight had substantial consequences, since the studies' findings were both unexpected and significant. Poorer therapeutic outcomes were observed in European and North American countries than in nations of the Global South.[56] The transnational studies also revealed unexpected variation in what had been considered pathognomonic or "signature" symptoms across sites. However, in the absence of ethnographic materials collected in tandem with clinical assessments, there was no empirical route to investigate the meaning of such results.

It was left to subsequent research to develop hypotheses and investigate possible sources of variation to account for the observed differences in the course and outcome. Among the most significant of these sources has been familial response or "expressed emotion"—emotions, attitudes, and behavior of kin toward ill relatives. Levels of expressed emotion likely account for some of the variation in who improves and who does not over time, and variation in levels of expressed emotion, in turn, can be accounted for partly by *conceptualizations* of mental illness—for example, personality defect, moral transgression, witchcraft, or cultural chemistry.[57] Another source of variation in course and outcome is the role of psychopharmacology, often the primary or only treatment available in some global settings, while other settings lack availability entirely. People who take psychotropic medications (and their kin) may seek medications for therapeutic benefits while at the same time grapple with paradoxes of the lived experiences of taking them.[58] Psychopharmacological practices blur the "conjunction of magic, science, and religion

with respect to pharmaceutical markets and global capitalism, on the one hand, and culture and lived experience of pharmacological agents, on the other."[59]

Many of the controversies surrounding the production, marketing, use, and misuse of psychopharmaceuticals are well rehearsed within medical anthropology. In the absence of working with people who actually live with mental illness and take medications to alleviate their condition, many critiques that target psychiatric biomedicine are remarkably distal or uninformed when applied to people who are afflicted.[60] While the argument in medical anthropology leans generally against psychopharmacology, the presumption in biological psychiatry often leans uncritically in favor. Both of these generalized stances are unproductive. The neglect of attention to culture and experience is particularly acute for practices of dispensing and taking psychotropic medications. Application of the concepts of experience and cultural validity in the realm of psychopharmacology has largely been precluded by the presumption that, as bioactive compounds, psychotropic drugs are "culture-free" and thus require little cultural and social attention. Recent ethnography shows that this is plainly wrongheaded. Our research makes clear that, while patients and kin value them for specific purposes, the meanings and practices surrounding these drugs produce what I have called medication-related paradoxes of lived experience. These conundrums can entail the valuation of improvement or symptom control while at the same time ambivalence about taking the medication.

While there is no shortage of controversy, or dilemmas, surrounding treatment with medications, it is clear that the drugs are actively sought worldwide by kin and those afflicted. Across low-, middle-, and high-income countries, people are generally aware of these drugs. For example, as Ursula Read has documented in Ghana, people not only actively seek out "hospital medicine" for mental illness but also sometimes use it in preparation for consultation with a religious healer.[61] At the same time, there is a deep longing for cure and dissatisfaction with side effects that may not help with work or social functioning.[62] The limitations surrounding psychopharmaceuticals affect people and their kin in ways that are remarkably similar and distinctive worldwide, as is detailed ethnographically in case studies from Ghana, India, Indonesia, Mexico, Tanzania, and the United States.[63]

There are opportunities to advance GMH in a way that takes seriously "No health without mental health," but this would require serious anthropological involvement at a collaborative design table. Within medical anthropology, there is debate and critique regarding the GMH endeavor, and it remains to

be seen how this actually will be taken up.[64] The work of medical anthropologists is not delimited to providing "vignettes" from, or clean-up of, jobs gone awry. As I have stressed in conferences with GMH leaders, the work of medical anthropology must be foundational to the entire enterprise. Failure to make it so will result in less than efficacious or sustainable partnerships in the service of improved mental health for all. Ethnographically and experientially attuned approaches to GMH can provide empirical grounding for doing away with the long-standing dichotomous mind-body separation and truncated attention to mental health merely as an "add-on" for infectious diseases (such as HIV/AIDS and tuberculosis).

Accomplishing this necessitates real collaboration, but it hardly requires going back to the drawing board, given the rich legacy of anthropological scholarship at the interface of anthropology and psychiatry that I referenced at the beginning of this chapter. But the legacy of social hierarchy within academic disciplines remains an obstacle to creating sustainable partnerships among primary stakeholders (patients, kin, providers) in local communities and among health policy officials. Without doubt, the core issues of sustainability and efficacy of partnerships and therapeutic care must be grounded in ethnographic knowledge and practice.[65]

A breakthrough to foster such an effort came in the spring of 2016 at a series of meetings in Washington, DC, cosponsored by the World Bank Group, the WHO, the National Institutes of Health, and Georgetown University. Entitled "Out of the Shadows: Making Mental Health a Global Priority," the meetings were an auspicious raising of political and social consciousness for mental health in its own right as a matter of human need and social justice. In an opening plenary address at the World Bank Group, Kleinman challenged three pervasive "myths": that mental illness is untreatable; that it is unimportant; and that caring for it is not cost-effective. Speaking from the nexus of psychiatry and anthropology, he asserted that "behind every data point there is real suffering."[66] At the end of the week, at a closing symposium, the powerful overall message was that we will get nowhere in the absence of generative theoretical models to guide our efforts. I have argued that any theoretically informed approach to GMH must take into consideration the decades of research in medical/psychiatric anthropology. Anthropological theory is critical to strengthen the intellectual and political platform from which to bridge the therapeutic concerns of GMH and the interpretive concerns of medical anthropology.[67] Constructing this bridge will require less formulaic and more nuanced anthropological analyses of the complex and paradoxical features of health care, considering experiential modes

of suffering and institutional processes for the provision of health care in a globalizing world. As Vikram Patel remarked in the above noted 2016 symposium's closing session, "When it comes to mental health, we are *all* developing countries."

As I have argued, efforts targeted at the "scaling up" of mental health care must be focused, effective, and sustainable. While economic and political constraints constitute the first obstacle to obtaining care, other obstacles are embedded in mental health policy worldwide that lacks sufficient political will for transformation. What is needed are tailored approaches to incorporate the social, cultural, and psychological contexts of mental illness and its treatment, on the one hand, and the socioecological context of environments in relation to socioeconomic and political conditions that can produce and exacerbate mental illness, on the other.[68] In the absence of in-depth and extended anthropological engagement, the GMH field could easily reproduce earlier follies within contemporary implementation and intervention sciences. "Culture lite" (as an example, through simplified or formulaic reference to idioms of distress) will not suffice for tackling core issues of cultural validity and therapeutic efficacy. Neither will indiscriminate discarding of psychiatric knowledge by some psychiatrists who, ironically, take cultural relativism further than most contemporary psychiatric anthropologists.[69]

Against the background of concern for what I have outlined as extraordinary conditions, we now have several decades of studies to demonstrate the breadth and depth of cultural and social processes as fundamental to the shaping of nearly every aspect of mental illness:[70]

- Risk/vulnerability factors (precarity)
- Type of onset (sudden or gradual)
- Symptom content, form, constellation
- Clinical diagnostic process
- Subjective experience and meaning of problem/illness
- Kin identification and conception of and social-emotional response to illness
- Community social response (support, stigma)
- Healing modalities and health-care utilization
- Experience, meaning, and utilization of health care/healing modalities (including psychotropic drugs)
- Resources for resilience and recovery
- Course and outcome

In practice, these factors, of course, are not only culturally shaped but form a matrix in which each factor can be inflected by the others. Severity of symptoms is inflected by cultural perception and attention to the symptoms; degree of disability/impairment is inflected by severity; and so forth. Behind all of this is the cultural definition of what counts as a problem in the first place.

In sum, just as there can be "no health without mental health," there can be "*no understanding of mental health without culture*." The concept of culture, largely out of fashion in cultural anthropology, as well as to medical anthropology, cannot be a casualty of translation or vogue. Cultural orientations and processes are more at issue than places or peoples, "beliefs" or behavior.[71] As Sapir set forth nearly a century ago, the locus of culture is dynamically created and re-created in the process of social interaction.[72] Cultural orientations are also critical for subjectivity and processes of attention, perception, and meaning that shape personal and public spheres. Such orientations are embedded generally in what Bateson called a community's ethos and what I more specifically have called a political ethos.[73] Through my studies I have found that a sustained ethnographic approach to the experience of mental illness should productively focus on engaged processes of struggle rather than symptoms. Struggle is intrinsic experiences of mental and neurological affliction, including the pernicious problem of discrimination (often referred to as social stigma).[74] Given this situation, it is necessary to advocate for continued research at the juncture of anthropology and psychiatry.

Notes

1 | Case study excerpted from Jenkins and Csordas, *Troubled in the Land of Enchantment.*
2 | US Census Bureau, 2017, https://talkpoverty.org/state-year-report/new-mexico-2017-report/.
3 | Kleinman, *Experience and Its Moral Modes.*
4 | Kleinman, *Rethinking Psychiatry.*
5 | Kleinman, *What Really Matters.*
6 | Jenkins, *Extraordinary Conditions.*

7 | Jenkins, *Extraordinary Conditions*.

8 | Neely Myers and Kristin Yarris have recently drawn together a collection of ethnographic works on the intersection of extraordinary conditions, psychiatric care, and moral experience: see Myers and Yarris, "Extraordinary Conditions."

9 | Jenkins and Barrett, *Schizophrenia, Culture, and Subjectivity*; Basu, "Listening to Disembodied Voices"; Becker, *Body, Self, and Society*; Biehl, *Vita*; Biehl et al., *Subjectivity*; Brodwin, *Everyday Ethics*; Carpenter-Song, "Children's Sense of Self in Relation to Clinical Processes"; Carpenter-Song, "The Kids Were My Drive"; Chen, *Breathing Spaces*; Csordas, "The Navajo Healing Project"; Csordas and Jenkins, "Land of a Thousand Cuts"; Das, *Life and Worlds*; Desjarlais, *Shelter Blues*; Dumit, *Drugs for Life*; Duncan, *Transforming Therapy*; Ecks, *Eating Drugs*; Farmer, "An Anthropology of Structural Violence"; Farmer, *Pathologies of Power*; Good, *Medicine, Rationality, and Experience*; Good et al., *Shattering Culture*; Hinton and Good, *Culture and Panic Disorder*; Hinton et al., "PTSD and Key Somatic Complaints and Cultural Syndromes among Rural Cambodians"; Holmes, *Fresh Fruit, Broken Bodies*; Jenkins, *Pharmaceutical Self*; Jenkins and Carpenter-Song, "The New Paradigm of Recovery from Schizophrenia"; Jenkins and Carpenter-Song, "Stigma despite Recovery"; Kleinman and Good, *Culture and Depression*; Kleinman, *Social Origins of Distress and Disease*; Lovell, "The City Is My Mother"; Lovell, "Tending to the Unseen in Extraordinary Circumstances"; Martin, *Bipolar Expeditions*; Martin, "Sleepless in America"; Myers and Yarris, "Extraordinary Conditions"; Read, "I Want the One That Will Heal Me Completely so It Won't Come Back Again"; Read et al., "Local Suffering and the Global Discourse of Mental Health and Human Rights"; Reyes-Foster, *Psychiatric Encounters*; Rhodes, *Emptying Beds*; Rhodes, *Total Confinement*; Whyte, "Health Identities and Subjectivities"; Whyte et al., *Social Lives of Medicines*; Yahalom, *Caring for the People of the Clouds*; Yarris, "The Pain of 'Thinking Too Much.'"

10 | Benedict, "Anthropology and the Abnormal."

11 | Sapir, "Culture, Genuine and Spurious," 235.

12 | Bateson, "Minimal Requirements for a Theory of Schizophrenia"; Devereux, "Normal and Abnormal"; Du Bois, *The People of Alor*; Hallowell, *Culture and Experience*; Sapir, *Culture, Language and Personality*; Kardiner, *The Traumatic Neuroses of War*.

13 | Canguilhem, *On the Normal and the Pathological*; Foucault, *Madness and Civilization*.

14 | Kleinman, "Depression, Somatization and the 'New Cross-Cultural Psychiatry'"; Kleinman, *The Illness Narratives*; Kleinman, *Patients and Healers in the Context of Culture*; Kleinman, *Rethinking Psychiatry*; Kleinman, *Social Origins of Distress and Disease*.

15 | White, "Culturological versus Psychological Interpretations of Human Behavior," 686–87. Whether reading the tables of contents within books or full ethnographies published prior to the 1970s, one is hard pressed to find accounts of, or even footnotes about, people with mental illness. As cultural actors, they scarcely make an appearance.

16 | See, e.g., Abrahams, "Ordinary and Extraordinary Experience," 45–48; Turner and Bruner, *The Anthropology of Experience*.

17 | Kleinman, *Experience and Its Moral Modes*; Kleinman, *What Really Matters*.

18 | Kleinman and Kleinman, "Suffering and Its Professional Transformation," 276, emphasis added.

19 | Kleinman and Kleinman, "Suffering and Its Professional Transformation," 276.

20 | This approach represents an intellectual departure from conventional approaches to psychosis, as represented in Aulagnier, *The Violence of Interpretation*; Kring and Johnson, *Abnormal Psychology*.

21 | Jenkins and Barrett, *Schizophrenia, Culture, and Subjectivity*, 7.

22 | Jenkins and Barrett, *Schizophrenia, Culture, and Subjectivity*, 7.

23 | Jenkins, "Schizophrenia as a Fundamental Human Process."

24 | Jenkins and Barrett, "Introduction."

25 | Jenkins, *Extraordinary Conditions*, 3.

26 | Jenkins, *Extraordinary Conditions*, 3.

27 | Jenkins, "Subjective Experience of Persistent Schizophrenia and Depression among Latinos and Euro-Americans," 23.

28 | Jenkins, *Extraordinary Conditions*.

29 | Jenkins, *Extraordinary Conditions*, 80.

30 | Kleinman, *Rethinking Psychiatry*, 15.

31 | Csordas, *Embodiment and Experience*, 38.

32 | Kleinman, *Social Origins of Distress and Disease*; Becker, *Body, Self, and Society*; Jenkins and Valiente, "Bodily Transactions of the Passions."

33 | Byron Good makes this argument in "Culture and Psychopathology."

34 | The project psychiatrist and the clinical psychologist on the research team were trained in administration and research reliability for this procedure in Jenkins and Csordas, *Troubled in the Land of Enchantment*.

35 | Jenkins and Kozelka, "Global Mental Health and Psychopharmacology in Precarious Ecologies."

36 | Carothers, "Frontal Lobe Function and the African."

37 | Field, *Search for Security*.

38 | Kirmayer and Robbins, "Three Forms of Somatization in Primary Care"; Tylee and Gandhi, "The Importance of Somatic Symptoms in Depression in Primary Care."

39 | Kleinman, "Depression, Somatization and the 'New Cross-Cultural Psychiatry'"; Kleinman, *Patients and Healers in the Context of Culture*; Kleinman, *Social Origins of Distress and Disease*.

40 | Kleinman and Kleinman, "The Appeal of Experience," 2.

41 | Kleinman, *The Illness Narratives*; Kleinman, *Social Origins of Distress and Disease*; Kleinman et al., *Social Suffering*.

42 | Robbins, "Beyond the Suffering Subject."

43 | Jenkins, *Extraordinary Conditions*, 266.

44 | Robbins, "Beyond the Suffering Subject."

45 | Canguilhem, *On the Normal and the Pathological*; Foucault, *Madness and Civilization*.

46 | Foucault, *Madness and Civilization*, 85.

47 | Kleinman and Good, *Culture and Depression*.

48 | Kolk and Hart, "Pierre Janet and the Breakdown of Adaptation in Psychological Trauma."

49 | Kardiner, *The Traumatic Neuroses of War*; Rivers, "The Repression of War Experience."

50 | Holmes, "Discussing 'Suffering Slot Anthropology' with Migrant Farm Workers."

51 | Prince et al., "No Health without Mental Health."

52 | Kozelka and Jenkins, "Renaming Non-communicable Diseases," e655.

53 | Walker et al., "Mortality in Mental Disorders and Global Disease Burden Implications," 334.

54 | World Health Organization, 1973, 1979.

55 | Sartorius et al., "Long-term Follow-up of Schizophrenia in Sixteen Countries"; Hopper, "Interrogating the Meaning of 'Culture' in the WHO International Studies of Schizophrenia."

56 | World Health Organization, *Schizophrenia*.

57 | Jenkins, *Extraordinary Conditions*; Jenkins and Karno, "The Meaning of Expressed Emotion."

58 | Jenkins and Carpenter-Song, "The New Paradigm of Recovery from Schizophrenia."

59 | Jenkins, *Pharmaceutical Self*, 3.

60 | Summerfield, "Afterword."

61 | Read, "I Want the One That Will Heal Me Completely so It Won't Come Back Again," 441.

62 | Jenkins and Carpenter-Song, "The New Paradigm of Recovery from Schizophrenia."

63 | Read, "I Want the One That Will Heal Me Completely so It Won't Come Back Again"; Ecks, *Eating Drugs*; Basu, "Listening to Disembodied Voices"; Duncan, *Transforming Therapy*; Good, "The Complexities of Psychopharmaceutical Hegemonies in Indonesia"; Whyte, "Family Experiences with Mental Health Problems in Tanzania"; Jenkins, *Extraordinary Conditions*.

64 | A recent summary of key issues and critiques is in White et al., *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health*.

65 | Kim et al., "Scaling Up Effective Delivery Models Worldwide."

66 | Arthur Kleinman, summarized in Mendenhall, "The Georgetown Symposium on Global Mental Health."

67 | Good, *Medicine, Rationality, and Experience*.

68 | Jenkins and Kozelka, "Global Mental Health and Psychopharmacology in Precarious Ecologies."

69 | Summerfield, "Afterword."

70 | The list is reproduced from Jenkins, *Extraordinary Conditions*.

71 | The concept of belief in medical anthropology imploded more than twenty-five years ago the wake of meticulous critique in Good, *Medicine, Rationality, and Experience*.

72 | Sapir, "Cultural Anthropology and Psychiatry," 236.

73 | Bateson, *Naven*; Jenkins, "The State Construction of Affect."

74 | Jenkins and Carpenter-Song, "Stigma despite Recovery."