Chapter 5

Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years

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Introduction

My purpose in this chapter is to ask a more general question of medical anthropology—What kind of field should it become over the next 50 years?—by raising five specific questions for one of its subfields: the medical anthropology of mental health. I am essaying the future, not the past. This is not the appropriate place to review the long and tangled history of the relationship between anthropology, psychiatry and mental health. What can be said here is that large-scale, long-term historical forces (including colonialism, racism, the programs of modernity, wars, mass migration, and globalization) have combined with internal changes in psychiatry, psychology, global public health and anthropology itself to reshape a chaotic, plural domain. Certain core themes that go back to the nineteenth century persist today; others have changed or disappeared; still others are newly emerging. Looking backward over the past fifty years, we can see that the central questions concern taxonomy (How do we classify mental health problems?); experience (What is the experience of mental illness and the mental hospital like? How do symptoms and syndromes differ for different classes, ethnic groups, and communities?); treatment systems and their interventions (How do we compare psychotherapies and folk healing practices, biomedical pharmacotherapies and traditional medicines?); culture (How to operationalize it in cross-cultural clinical settings and for cross-national comparisons?); policy (Can most mental health problems in low resource settings be handled in primary care? Is the outcome of schizophrenia really better in poor non-Western societies?); political economy (How determinative are the structural sources of distress and disease?); and social theory (Stigma; total institutions; biopower and

governmentality; habitus; medicalization; etc.—How useful is it to apply these conceptual tools to mental health?).

An earlier cultural critique of stress and its place in psychiatry has morphed into a cultural critique of PTSD and the humanitarian assistance community that has adopted it wholesale. Cultural critique itself is being supplanted by implementation and intervention studies where the anthropologist is not only a responder but, as is the case with Byron and Mary-Jo Good in Aceh, has developed the interventions (Good, Good and Grayman 2009). The ethnographic study of the mental hospital has been replaced by rich ethnographies of the social course of chronic mental illness. Engagement with psychiatric and psychological science has moved beyond the problems of existing research methods to the development of new anthropologically-informed research approaches. And anthropologists have interpreted entire national psychiatric training and treatment systems, including Tanya Luhrmann's intrepid and important account of American psychiatry (2000).

It is also my personal observation that just as psychiatry has moved away from social research and the social sciences, almost turning its back on anthropology in its romance with genetics and neuroimaging, anthropology has gotten much more involved with infectious diseases, the female reproductive life cycle, transplantation surgery, biomedical research, and bioethics, and, while not turning away from global mental health, has become less excited by it. (This is visible in my own career as a teacher, where out of 75 former and present Ph.D. students whom I have supervised, only a few have chosen to study psychiatry and mental health. It is also clear in my role of advocacy

for mental health at global health meetings, where I am usually one of only a small number of anthropologists.)

But what should be the central questions for the anthropology of mental health over the next fifty years? And what do those questions tell us about where medical anthropology will be in that future era? The five questions I adumbrate are the ones that I believe can advance an intellectually strong, academically robust mental health sub-discipline as well as the larger field of medical anthropology. They are what excite me after four decades of thinking about this disorderly and perhaps no longer so popular, yet still highly resonant, field.

The Five Questions

(1) What is the difference between social suffering and mental health problems (or psychiatric conditions)? And how does that difference make a difference?

The term "mental health" was developed to encompass not only dementia, psychosis and depression/anxiety disorders, but also to include a wider set of problems from substance abuse, serious school failure and family breakdown, to violence and its traumatic consequences. In extending the reach of authorized mental health categories to include both clear-cut disease and vaguer, though no less serious, problems of everyday life as well as non-medical catastrophes, the term mental health became an unwieldy, even an unbelievable, odd lot – now in DSM-IV (and soon DSM-V) with hundreds of subcategories. It seems to simultaneously trivialize the most serious of medical conditions and to medicalize social problems. I predict that by 50 years from now this category will have been abandoned. Nonetheless, the problem it represents – what

George Canguilhem ([1966] 1989), George Devereux (1967), and Michel Foucault (2003a) called the central theoretical problem for medicine: namely the distinction between the normal and the pathological – will, I believe, continue to bedevil our field and the health-related social sciences, ethics and humanities more generally.

The simple reason for this is that social suffering and illness overlap, not entirely, but substantially. Economic depression and psychological depression and societal demoralization/anomie are systematically related, as Vikram Patel's (2003) epidemiological review and Clara Han's (2007) ethnographic research powerfully demonstrate. Political economy creates suicide just as surely as genetics does. Global social disruptions contribute to substance abuse. Political and moral processes underpin the stigma of psychosis and cognitive disability just as they provide the structural basis for psychological and family trauma. Contrary to psychiatric epidemiologists' focus on one disease at a time, in the toxic and predatory environments of urban slums and shantytowns worldwide, depression, suicide, violence, PTSD, and substance abuse cluster together—the very terrain of social exclusion, health disparities, and social suffering.

The term "social suffering" was coined by Veena Das, Margaret Lock and me to emphasize how ordinary social life everywhere is experienced as pain and suffering at least as much as joy and happiness, and that such collective pain and suffering is normative and normal (Kleinman, Das and Lock 1997). Social suffering also referred to extraordinary human experience from the social consequences of individual catastrophes to collective disasters. The term indicated that the ethnographer of human tragedies, including serious disease and grinding poverty, almost always finds that the suffering that

results is interpersonal. And it was intended to connote one other thing: that our very processes of meaning-making – personal as well as cultural – grew out of, and sustained, the same societal forces that created the social and individual conditions of injury, disorder and disablement. Bureaucratic meaning-making indeed rationalized social suffering as theodicy and sociodicy with all the sad implications Max Weber foresaw: an iron cage of rationality (now protocols and regulations) that replaced human emotion, spontaneity and indigenous tradition (Diggins 1996). Institutions created to respond to suffering, say the mental hospital or social welfare agencies or humanitarian NGOs, ended up contributing to it.

Seen this way, not all psychiatric disorder is social suffering; nor does social suffering always create or intensify psychiatric disorder. The framework of suffering also makes less useful the concept of medicalization, which has become so powerful in our time. Emphasis, I predict, will shift from psychiatric medicalization to the relationship between psychiatry and social suffering. We (medical anthropologists and global health experts, though not psychiatrists) will, as is the current case with cardiovascular disease, diabetes and stroke, come to see many cases of depression and anxiety disorder as forms of social suffering as well as consequences of social suffering. We will come to understand, too, that suicide is more often a response to social suffering than a consequence of a psychiatric disorder, though we will also be comfortable that it can be both.

Sociologists, anthropologists, historians, and social epidemiologists will, I predict, open the field of the embodiment of social suffering – which Joan Kleinman and I once

referred to as how bodies remember – in such a large-scale way as to help psychiatry recreate a robust academic research enterprise of social and cultural psychiatry and psychosomatics (now understood as sociosomatics) as well as mental health care policy to develop a much stronger social policy connection (Kleinman and Kleinman 1994). Indeed, anthropology's reach will be as strong in the public health side of mental health as in the clinical side.

The question for anthropology and psychiatry and public health, then, will not be on the classical order of the normal and the abnormal; but rather will involve a much deeper phenomenology of the forms of social suffering; an epidemiology of the causes and consequences of social suffering; and the implementation science of policy and programs for that subset of social suffering that is represented by psychiatric disorder as well as for psychiatric conditions that are not tied to social suffering. Either/or thinking will weaken, just as a more complex and sophisticated understanding of both societal and biological processes will advance the view that normality as well as disease embodies social suffering.

(2) If, as I have recently argued,[i] *ground zero for patients with psychosis globally is moral death and social exclusion, what is the implication for medical anthropology research of going beyond stigma to redefine in cultural terms what is at stake in the most severe psychiatric conditions?*

In the August 23, 2009 issue of *The Lancet*, I argued that ground zero in global health for patients with psychosis is not the 15% of the global burden of disease accounted for by mental health conditions, nor is it the tragic gap between that huge

figure and the paltry 2%, and more usually 1%, of the funding on health which gets directed to the treatment and rehabilitation of mental health conditions in low and middle-resource societies. But rather ground zero in global mental health is the appalling ways in which people with psychosis are treated almost all over the world (there are a few exceptions) by professionals, family members, traditional healers, communities and the state (Patel, Saraceno and Kleinman 2006). In China, these individuals are turned into non-persons, so that they are socially dead and morally unprotected from the most basic infringements of dignity, personal rights, even life itself. Although I have contributed to efforts to reformulate the concept of stigma to encompass this nullification of personhood and negation of moral status, I have serious doubts that this can be done (Yang and Kleinman 2008). So, I seek to question how medical anthropology will relate to the subject of stigma. And I propose that we begin to consider abandoning this concept – which has become so psychologized and conventional that it seems to me, at least, an unuseful euphemism – in favor of rethinking the catastrophic moral consequences of the dehumanization of the mentally ill (and also AIDS patients, sufferers of leprosy, those struggling with epilepsy, etc.). What happens when this failure of humanity is reinvented as social death, moral defeat, and cultural exclusion (Guo 2008)? It requires a more powerful ontological line of analysis to get at what is an entirely different way of being in the world. Biography, ethnography, and documentary film can evoke this fundamental condition of humiliation and exclusion as a non-human status. It is that ontological reality that provides a more adequate ground for research and policy responses. And also for real caregiving.

But what are the gains and losses of abandoning the concept of stigma to the psychologists and sociologists? Sadly, not much, I have come to conclude. With the exception of Bruce Link and colleagues' inclusion of power as a heretofore entirely missing social moderator of stigma, the subject is still configured in the cognitive behavioral and labeling theory approaches of the distant past (Yang et al. 2007). Neither allows the opening to experience and its ontology which medical anthropology is almost uniquely suited to advance. The impact of prioritizing the ontology of experiences of human abandonment and social death will keep medical anthropology more generally centered on experience, which I have argued and will continue to argue is its most significant object of enquiry.

(3) The paradox of global pharmaceuticals for psychiatric disorders (under-diagnosis and absent treatment for the poor; over-diagnosis and abuse of treatment for the middle class and well-to-do): how is it to be operationalized in theory and empirical studies? And where will pharmaceutical and other biomedical research end up in medical anthropology?

Like the other questions, this topic exceeds the boundaries of mental health and is important for all non-communicable and communicable diseases. The paradox goes as follows: at the same moment that most people with mental illness, especially those in poor societies and in poor parts of resource-rich societies, go undiagnosed and untreated for serious yet treatable psychiatric disorders, others, especially those in high technology and richly resourced urban centers, are being over-diagnosed and inappropriately treated with pharmaceuticals, including expensive brand named drugs, for conditions that are

either minor or medicalized. The chief cultural critique of anthropologists working on either global pharmaceuticals or mental illness has focused on the latter, the misuse and abuse of psychopharmaceuticals (Petryna, Lakoff and Kleinman 2006). And this is an important contribution. Relatively little ethnographic attention, in contrast, has centered on the state's (especially middle and low income states') failure of responsibility to protect the mentally ill by providing health care services such as appropriate psychopharmaceuticals, and also including resources that support families who are placed under the greatest financial, social and moral pressure. This research is urgently needed to balance the ethnographic picture. Such balance should extend to serious study of traditional pharmacology and its commercial networks, abuses and consequences. In fact, biomedical technology and bioengineering also need to be included in this framing of the mental health paradox. And of course this is precisely where medical anthropology is enriched by the ethnography of science (see Martin 2007 and Petryna 2009).

Up until the late 1980s, there was no significant stream of research in medical anthropology devoted to biomedical science (Lock and Gordon 1988). In recent years this stream has gotten stronger and stronger (see Biehl 2009, Cohen 1998, Petryna 2006, Rabinow 1999). The study of the offshoring of pharmaceutical (especially psychopharmaceutical) research has raised basic questions about methodology (e.g., bias in sample selection, problems with randomized controlled clinical trials) and ethics (i.e., questionable use of placebo controls, conflict of interest among researchers, loss of basic medical care once studies have ended). Anthropological studies have also unpacked

neuroimaging (Dumit 2003) and genetic research for neuropsychiatric conditions like dementia (Lock 2007), in so doing calling into question the ideology of evidence-based psychiatry. And yet even here, the thrust of interpretation of findings within the field as a whole has emphasized overdiagnosis and overtreatment. Medicalization still continues as the leading interpretive scheme in the ethnographic study of biotechnology in mental health (Horwitz and Wakefield 2007).

So, we can say that medical anthropologists, myself included, have seriously distorted the study of treatment for mental illness by failing to adequately examine the effects of absent or inadequate services, including as they relate to the psychiatric science industry. There is an impressive anthropological literature on the experience of psychiatric treatment in the U.S. and Europe, to be sure (see Bourgois 2009, Desjarlais 1997, Estroff 1981, Garcia 2010, Hopper 2003, Luhrmann 2000, Rhodes 2004, Scheper-Hughes 1979). But little like this literature exists for the treatment and research experiences of the mentally ill in poor and middle-income societies. If anthropology is to advance global mental health, this omission must be corrected. We need ethnographic studies, then, of the intersection of biotechnological and bio-engineering research with mental health care policies and programs.

The question, then, is what happens when we rebalance the medical anthropological emphasis on medicalization with an equivalent emphasis on the absence of psychiatric, psychological and other professional mental health services that makes unavailable psychopharmacological, psychotherapeutic and rehabilitation interventions. What happens when we see the state not primarily as the source of powerful control over

the mentally ill and through them society at large, but rather as fragile, constrained, and almost powerless to provide the most basic care for its most impaired and vulnerable members? Some refashioning of the research agenda like this is needed if anthropology is to be serious about the study of mental illness. When it comes to the theoretical reframing of such work, it is time to supersede Foucault (1989) and Scheff (1975), French psychoanalytic theory, labeling theory and ideas of the colony and post-colony, with a deeper, more original understanding of our unprecedented times. History continues to matter for ethnographers of the present, but so do futuristic explorations of a new age, a watershed era of transition that is creating conditions that are entirely new, including new subjectivities and new ways of living a disease. In a forthcoming book, seven colleagues and I, all China anthropologists and psychiatrists, examine the deep change in subjectivity in today's largest and most dynamic society: China (Kleinman et al. in press). We identify a basic remaking of individuality and moral life that is associated, inter alia, with substantial rates of mental illness, substance abuse and suicide. A parallel Chinese development is the professionalization of psychiatry and a psychotherapy boom. Tied to this is the psychopharmacology paradox but also the development of major research programs in biotechnology, including bioscience targeting mental health problems. To understand what is happening we developed a theory of the divided self in contemporary China that ties personhood to changes in moral experience in different local worlds and that engages China's diversity and plural life worlds. This shifting moral-emotional ground is the platform on which symptoms and syndromes, from neurasthenia through depression, to eating disorders and psychosis, are being

remade, and with them treatment and public health systems are also undergoing substantial change, change that indexes the scope and depth of China's great new cultural transformation from a primarily rural and younger to an increasingly urban and older society, from a primarily poor to an increasingly middle-class society, and from a society in which the person owes her/his life to the state to one in which the state owes each of its citizens an adequate life. To understand health and mental health in China is to come to terms with this huge transformation in ordinary life. Hence theories of how societies change and theories of how individuals change take on a central significance for understanding changes in subjectivity, psychiatry, and the political and moral economy of health care.

(4) Ethics, Forensics and Caregiving: how do they fit into the medical anthropology of professional psychiatric and family-based mental health care?

The 1980's and early 90's can now be seen as the heyday for the medical anthropology of caregiving. Numerous studies focused on clinical care by physicians and nurses, and by traditional healers and laypersons.[ii] Some important work continues in areas like nursing, disability and special, increasingly high technology arenas like cancer care and transplantation (see for example Sharp 2006 and Kaufman 2005, among others). Yet, we seem to be losing touch with this crucial subject just as we are building real strength in public health. Hence, global health seems to have almost nothing to do with caregiving. This must not happen. Medicine's failure in caregiving remains one of the great narratives in the social science and humanities study of medicine (Kleinman 2008, 2009b). Nowhere is this failure more devastating than in the field of caregiving for

psychosis, dementia, autism, and severe cognitive impairment of children (Kleinman 2009a). Where is the ethnography of today to match the works of the past? Think of William Candill and Jules Henry's classic studies of caregiving in the mental hospital; Kim Hopper (2003), Norma Ware (Ware et al. 2007) and Sue Estroff (1981) on the chronic mentally ill; and Bob Edgerton (1993) on the cognitively impaired. Given the enormous changes in health care systems worldwide and the widespread failure of global public health workers to privilege quality caregiving, this is just the moment for such work. There are also remarkable developments that cry out for study, such as America's failure to include caregiving practices in health care financing reform and Holland's largely unsung efforts to make caregiving practices central to medical education and practice.

So my first question in this area is, where is the ethnography of caregiving today for mental health problems (including substance abuse), and what does it tell us about the way health care – professional and family – is being transformed in our times? (For exceptions, see Bourgois 2009 and Garcia 2010.) Part of that professional transformation is the development of higher practice standards in psychiatry and psychiatric nursing, as well as the introduction of modern forensic and ethics approaches to mental health care. The continued misuse of psychiatry in China for political and policy purposes is not the same as the systematic abuse of psychiatry in the former Soviet Union, for example, but instead can be seen as a problem in the uneven professionalization of psychiatry, in the poor standards of professional care, in the failure to build modern forensic programs, and most notably, I believe, in the lack of serious attention to ethics: a problem found in

medicine throughout East Asia. The existing evidence points to the failure of an Asian equivalent to the Nuremburg Trial and Code following the horrendous abuse of medicine through the Japanese Imperial Army's biowarfare research on Chinese civilians during the long war with Japan. The U.S., Japan, and both Nationalist and Communist China are implicated in this failure of justice. But the long-term consequence seems to have retarded development of modern ethics (especially indigenously based ethics) and led to the superficial and hegemonic imposition of NIH-style bureaucratic ethics on global research (Nie et al. in press 2010). Much more needs to be done to unpack the question of the comparative cross-cultural ethics of caregiving. And that research will lead us not only to a new consideration of bureaucracies and institutions, but also, and more radically, to a deeper appreciation of the transformation of subjectivity in our times that I have already discussed (Biehl, Good and Kleinman 2007). Moral-political change is creating a new personhood in many societies. Here medical anthropology will return to its long-term association with psychological anthropology, a relationship that thinned out over the past decade, as medical anthropology took an increasingly structural violence approach and focused more on infectious disease and chronic medical conditions than on mental illness, and as psychological anthropology moved away from the study of illness toward questions of cognitive neuroscience and cognitive psychology.

(5) Culture and the new neurobiology: how to reframe science and society in the golden era of brain research?

We are living through what natural scientists call the golden age of neurobiology. It is no longer reasonable for medical anthropologists to add footnotes to Marshall

Sahlins' (1976) dated, not to say poorly informed, "The Use and Abuse of Biology." Cultural critique still has a place, but it must be a scientifically informed critique, otherwise we cede the field to STS program graduates, few of whom in my experience posses adequate training and real skill in ethnography to resist the imposition of a programmatic theoretical framework that represents the current day equivalent of hegemonic political economic frameworks of the past.

It doesn't take that much insight into global culture today to recognize that the new neurobiology is recasting both cultural common sense and professional scientific logic about cognition, affect and abnormality. How will anthropology's long-term interest in mental illness and psychiatry be affected by the huge wave of interest in and greatly transformed knowledge base of neurobiology? I myself, though medically trained and in possession of a postgraduate course in neurology, albeit in 1966, feel unprepared to adequately encompass the new neuroscience. Just as my former students Paul Farmer and Jim Kim insist on a biosocial approach to the leading infectious diseases in global health, so too do I wish to advance a biosocial approach to global mental health. This should become—in my domain—just as core to the "Harvard School of Medical Anthropology" as are the emphases on lived experience, structural violence and what is morally at stake for individuals and collectives.

Conclusion

These five questions are shorthand for a blueprint of what the anthropology of global mental health might become in the future. In 1995, Robert Desjarlais, Byron Good, Leon Eisenberg, Anne Becker, Mary Jo Good, Norma Ware, Sue Levkoff, Myron Belfer, and

others of my Harvard colleagues and I published *World Mental Health* as a perhaps precocious and somewhat transgressive effort at integrating anthropological and psychiatric perspectives. It may now be a more propitious time to undertake a new effort at thinking through global mental health, and medical anthropology should play a larger role in that rethinking. Because psychiatry and psychology have made such a minimal contribution to global mental health, this is a field where medical anthropology could and should play a central role in defining the subject and laying out the research questions, but also developing the advocacy, policies and actual interventions. Those medical anthropologists, especially, who are cross-trained in medicine or public health, and who possess a mental health focus, should feel empowered to develop the field of global mental health interventions. In this sense, the very backwardness of the field should be a spur to medical anthropologists.

To do so, of course, as in the example of the global AIDS field, is to risk being criticized for stepping out of the classroom and library and into the field, not only to do research but to link that research to interventions. Just as Paul Farmer, Jim Kim, Richard Parker, Didier Fassin and others have created a kind of experimental anthropology based on field interventions in the area of infectious disease, this is an important direction for anthropology in global mental health.[iii] Phillip Bourgois's (2009) efforts to move beyond description of homeless drug addicted people in the US and assist them with negotiating the health care system as well as intervening on their behalf for public health practices that benefit these destitute yet difficult individuals is also a pertinent example.

The gist of my argument is that we have entered a new era in the social anthropology of mental health and in medical anthropology in general. This new era requires a rethinking of our objects of enquiry. It is an increasingly interdisciplinary era in which anthropologists must become more comfortable in collaborating across methodological and professional divides. It is an era in which anthropologists also cannot avoid contributing directly to public health (Hahn and Inhorn 2009) and clinical interventions (Farmer 2010). And it is a time when we must recreate our field through new theories, new research questions and new approaches. In my view, we are in a period of moving from the margin to the center… of our discipline and of our subject matter. Whatever uncertainty we have of taking on much greater responsibility needs to be balanced by recognition of how much interest there is in our subject and in our works by students, professionals and laypersons who are demanding much more from us. Not the least of all, they want our contributions to make a difference out in the world. And we should too!

Notes

[i] Kleinman, A. (2009) *Global mental health: a failure of humanity.* The Lancet, vol. 374.

[ii] Balsham 1993, Boddy 1989, Bosk 1979, Bourgois 2009, Cohen 1998, Crandon-Malamud 1991, Estroff 1981, Farmer 1992, Farquhar 1994, Frankel 1986, Garcia 2010, Good 1994, Good et al. 1994, Helman 1992, Ingstad 1992, Janzen 1978b, Kleinman 1980, Laderman 1991, Leslie and Yang eds. 1992, Lock 1993, MacCormack 1992, Madan 1980, Martin 1987, McGuire 1988, Reed 1983, Rhodes 1991, Roseman 1991, Sargent 1989, Scheper-Hughes 1979 and 1992, Wikan 1990.

[iii] I am thinking here of work with Partners in Health, Medecins Sans Frontieres, the World Health Organization, NGOs in Brazil and other intervention programs.