Medical Anthropology Quarterly

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From Person to Life: An Anthropological Examination of Primary Health Care Approach to Depression in Rio de Janeiro

Mental illness approaches in public health have resulted in controversies around the adequacy of interpretative and therapeutic models. These controversies engage polarized debates amid understandings of mental illnesses either as brain disorders or as socioculturally determined entities. Aiming to investigate how mental health care is implemented in a Latin American metropolis, we conducted an ethnographic study of the approach to depression in a primary care unit in Rio de Janeiro between 2016 and 2017. "Life" emerged from our fieldwork as the main local category for understanding the experiences of patients with depressive symptoms and the work of reengagement performed by family physicians. With this investigation, we seek to provide insights into an approach to mental illness in primary health care that moves away from polarized interpretive frameworks and remains open to the singularities of patients' experiences of suffering. [Brazil, depression, life, reparative ethnography]

> "Francisca, go on living." (Jaime, family medicine resident)
>
> "No, I won't go on living." (Francisca, after her son was killed by the police)

Introduction

Expanding access to mental health care is considered an important global public health challenge (Editorial 2020; WHO 2019). Disorders, impairments, and

MEDICAL ANTHROPOLOGY QUARTERLY, Vol. 36, Issue 1, pp. 64–82, ISSN 0745-5194, online ISSN 1548-1387.
DOI: 10.1111/maq.12668

difficulties attributed to the mind—either by health professionals or patients—demand wide recognition and treatment in public health services (Finley et al. 2018; GBD 2017 2018). At the same time, there are controversies and disputes about the appropriate approach to the classification and treatment of mental illnesses, shaping the ways in which those conditions are made visible and legitimized within those services (White et al. 2017). These controversies involve a wide span of positions, ranging from polarized understandings of mental disorders as either brain disorders or socioculturally determined entities (Kirmayer and Crafa 2014; Ortega and Wenceslau 2015) to more hybrid or complementarity proposals, such as the "bio-psycho-social model" in mental health (Babalola et al. 2017).

Ethnographic research has evinced that the experiences of people with mental disorders do not reproduce the ontological binaries—mind/body, biological/social—underlying the diverse explanatory models of mental illness (Ecks 2021; Jain and Orr 2016). Moreover, health professionals have promoted care practices that do not reify those binaries. Family medicine constitutes one potential setting for modeling alternatives to the dichotomies in mental health care (Bonet 2014). In family medicine, mental health is understood as indissociable from any experience of well-being, illness, and care. It replaces the traditional clinical method, centered on physical disorders and biomedical diagnoses, with "a patient-centered clinical method" (Freeman 2016: 203–9), which focuses not only on patients' "anatomophysiological disease" but also on the re-signification of their "psychosocial illness" (Helman 1981; Stewart et al. 2014).

This article presents an ethnographic account of family doctors' and residents' care practices for people with depressive symptoms at a public primary health care unit in Rio de Janeiro, Brazil. We believe that anthropological approaches that problematize binaries and dualisms within anthropology itself contribute to the understanding of the local clinical practice examined in our fieldwork, which likewise problematizes those divisions within mental health care. Our research builds on several anthropological studies in Brazil (e.g., Bonet 2004; Menezes 2000) that examine the encounter between biomedical agents' "individualized or individualizing representations" and patients' "holistic representations" of health and disease (Duarte 2003: 177). We draw on the theoretical framework developed by Brazilian anthropologist Luiz Fernando Duarte, who criticized[1] the categories underlying the ontological division between mind and body—such as mental vs. physical; psychosocial vs. biomedical—and focused on the experiences of "physical–moral disturbance" afflicting Brazilian urban working classes (Duarte 1994). Based on Duarte's conceptualization and our own ethnographic fieldwork, we argue that interpretations that naturalize those dualistic binaries are not useful for understanding family physicians' approach to depression.

We observed that, for professionals and patients alike, "life" emerged as a central category for understanding and managing depression. Depressive episodes may be described as experiences of "impaired life" and their care as a path of reengagement with life. Moving away from an emphasis on the "'dark side' of life" (Fassin 2009: 57), in our ethnographic research, life corresponds to the movements of the bodies and subjectivities of people with depressive symptoms that unfold through their relationships, projects, family relations, and social activities.[2]

We draw on concepts developed by Tim Ingold to explore the "ethical possibilities" (Lambek 2010) of this practice of reengagement with life. In Ingold's words, anthropology "is a sustained and disciplined inquiry into the conditions and potentials of human life" (Ingold 2011: 3). He defines life "as the name for what is going on in the field of relationships within which organic forms emerge, develop and are held in place" (Ingold et al. 2012: 11). For physicians and patients in our ethnographic research, depression involved the stagnation of the flows and movements that occur within this "field of relationships" and the therapeutic approach we observed envisaged a re-attachment with these flows and movements. We examine family physicians' and residents' care practices with the help of Ingold's notions of "meshwork" (2010) and "education of attention" (2001, 2018) to shed light on the strengths of such an approach to depression that may hold lessons for policies and practices elsewhere.

Various forms of violence suffered by people with symptoms of depression, their experiences of malaise and disturbance, and the efforts of professionals to offer a comprehensive approach to these situations convinced us to concentrate on the "reparative" potential of the care practices we observed. Based on the work of Eve Sedgwick (2003), Dominique Béhague and Kenneth MacLeish argue that an examination of the "global psyche" and the diverse experiences that embody this polysemic notion should depart from a hermeneutics of suspicion and explore, through "reparative ethnographies," "practices of creativity, refusal, and the embrace of uncertainty," as well as the potential of these practices as "exceptions" to the "overarching trends" (Béhague and MacLeish 2020: 8, 17) of oppression and violence that weigh on the lives of the poorest and most marginalized people around the world. A reparative anthropological perspective contributes to unveiling the reparative potential of the local mental health approach examined in our fieldwork.

This study was carried out at a family health strategy (FHS) unit in the north of Rio de Janeiro over the years 2016 and 2017.[3] FHS is the Brazilian model of primary health care (Macinko and Harris 2015), and a FHS team consists of a physician, a nurse, a nursing technician, and a variable number of community health workers. Together, the team members are responsible for primary health care, including mental health, for a population stretching from 2,000 to 4,000 people dwelling in the same geographical territory. Fieldwork covered a shorter and exploratory phase (April 2016) and a longer one (January–March 2017) during which we interviewed 18 professionals—mostly physicians and residents, but also nurses, psychologists, and one psychiatrist—along with 22 patients. The 22 selected patients were those who, within the universe of observed consultations, were recognized by physicians as having "depressive symptoms," some of which were diagnosed with "depressive episodes" (WHO 2020). In the longest phase, we followed the consultation routines of six resident physicians and two clinical preceptors from four FHS teams, involving around 180 medical appointments, home visits, and emergency room calls. This three-month participant observation period accounts for the core of this article. The research project was approved by the Research Ethics Committees of the Institute for Social Medicine of the State University of Rio de Janeiro and of the Health Department of Rio de Janeiro.

We present our empirical material in three parts. First, we examine the meanings of depression in the research scenario and the centrality of life in patients' and professionals' representations. Second, we explore doctors' and residents' approach to the care of people with depressive symptoms, focusing on their main therapeutic resources: the patient-centered clinical method, medications, and patient groups. Drawing on Duarte's (1986, 1997) and Ingold's (2011, 2018) concepts, we shed light on how this local approach deviates from reductionism and binaries in the care of these experiences of malaise and suffering. Finally, we highlight the "reparative" potential of such an approach to depression, which may hold lessons for policies and practices elsewhere.

"Half-death"

The first stage of our research involved exploring what patients and physicians understood by depression in their local context. When asked, "How would you describe your health problem?" or "What is depression for you?" patients used a variety of expressions, such as "anxiety," "nervous," "stress," "anguish," "despair," "agony," "distress," "overload." They also described bodily discomforts (shortness of breath, muscle or bone pain, chest pain, tightness, or void). These local idioms and sensations were mainly associated with difficult or traumatically interrupted relationships with their children, parents, and partners, and to personal projects, for example work- or education-related dreams that did not come true.

Depressed individuals described themselves as being without alternatives and stuck in important, if not essential, aspects of their lives. For Nilda,[4] a 50-year-old Black woman, her health problems involved an excess of "things" that made her not want to leave the house: "I really call it depression, anguish, sadness, a lot that just comes to me. Everyone leaves, everyone works, everyone has a commitment—'Nilda can handle everything she has to do.'" Francisca, a 66-year-old Black woman, described how her son was murdered in her arms and the personal impact of that memory:

> He [her son] went down with me from here down there to the UPP's [community police unit] entrance. When he got there, someone kicked me, offended me and I fell to the ground holding him. I was under him, and he was over me and they started shooting, you know? But God protected me so that I didn't get shot, the bullet just grazed me like that. And he died. And from then on, I felt that I was like this, like a tree. I wilted. I was not the same Francisca I once was. I used to be a dancer, I used to be a model and to do fashion shows. And now I don't want to go on living. But Jaime [family medicine resident] says, "Francisca, go on living." No, I won't go on living.

For physicians, the main feature of depression was "dysfunctionality" (i.e., a significant impairment affecting patients' work [including domestic work], leisure activities, and especially social relationships). In the words of family medicine resident Lívia, a 28-year-old White woman, depression resulted in an "impaired life" (*comprometimento da vida*). For Jaime, a 29-year-old White man and family medicine resident, depression involved "stop feeling," a feeling of emptiness, a pessimistic view of reality: "Depression: you are there, in your corner, you don't feel anything, you can't feel anything, I don't want to feel anything. Depression is half-death in that sense." Family physician Marisa, a 30-year-old White woman, portrayed her view on depressive conditions in this way:

> To think of it [depression] as a lack of substances does not make sense. But it [the understanding of depression as a lack of substances] makes sense from the moment you understand that everything, including hormone production comes from *your life*, right? It comes from your senses, from your external conceptions. It wasn't like you suddenly stopped producing some substance. Of course, you won't understand everything from there, right? With Tânia [a patient] (…), you understand all the losses she has endured, all the abuse she has suffered, all the abuse she suffers today, it is still much more important than any medication I prescribe her. For me depression comes from there (emphasis added).

Although using different expressions, both physicians and patients described depressive episodes as experiences of interruption or stagnation of life. Life was depicted as sets of attitudes, behaviors, and practices that favored the fulfillment of desires and expectations around one's own intentions and family relationships, especially with children and parents. Deaths, distances, and conflicts affected these relationships and resulted in depressive episodes. For Jaime, life was "everything that moves, transforms; every possibility of exchange." This understanding was shared by research participants, professionals, and patients who believed that taking care of depression entailed helping patients to reengage with the "movements" and "transformations" of life.

Our interlocutors Nilda and Francisca were hill dwellers whose neighborhood was served by one of the teams we accompanied in our fieldwork. Paradoxes and social divisions permeate the social organization of the Rio de Janeiro population, which has been studied in the last few decades chiefly through the lens of the division between hill and asphalt (Ventura 1994). Over the years, part of Rio's low-income population has settled on the city's hills, forming the *favelas* [slums]. The city's high-income citizens usually live by the sea in elegantly planned neighborhoods and gated communities—locally referred to as the asphalt—in contrast to the hills, where urban development has little in the way of formal planning and often lacks proper infrastructure.

Nilda and Francisca were "matriarchs of the hill" (*matriarcas do morro*), a local category used by doctors and residents to describe what they considered the main population segment affected by depressive symptoms in the favelas: Black women over 40, with life trajectories marked by experiences of physical and structural violence, who were responsible for the domestic care of two or even three family generations. These women were commonly in charge of economic provision (through government aid and informal jobs) for companions, children, and grandchildren—all of whom were men, frequently drug users or traffickers, who often committed domestic violence against these women (Wenceslau and Ortega 2020). Nilda and Francisca lived in small houses, hot and humid, with poor lighting and ventilation, surrounded by improvised open sewage pipes. When we visited them during our fieldwork, usually in the morning, they were always involved in housework and at the same time trying to take care of one or more "lap" grandchildren who lived with them.

When we followed people from the hill and the asphalt, we repeatedly witnessed instances of Brazilian structural racism (Almeida 2019). Most of the patients on the hill who we accompanied during consultations and home visits were Black women. On the asphalt, most patients were White, with a greater balance between men and women (four men and six women). Out of the six resident physicians who participated in our research, four self-declared as White and two as Black. Although we did not build our sample aiming at being representative in sociodemographic terms, considering that most of the Brazilian population is Black (55.8%), our research portrays the lack of access to income (of the 10% of the population with lowest income in Brazil, 75.2% are Black), lack of adequate housing conditions, and lack of higher education for Black Brazilians (IBGE 2019). The racialization of structural violence was acknowledged by the professionals in our fieldwork, who considered depression resulting from the rupture of the main "support pillars" (mainly, relations with children and grandchildren) who kept people's lives "in flux." This rupture also resulted, according to the doctors' perception, from the sum of the various forms of abuse that the matriarchs of the hill suffered for being women, poor, and Black.

The interviews, home visits, and consultations with Nilda, Francisca and other matriarchs were always marked by narratives of distressing experiences involving remembrances of violent deaths or imprisonment of children and grandchildren; shootings on the hill; episodes of aggression by their partners when under the influence of alcohol, cocaine, or crack; and the burden of caring for elderly family members with chronic diseases such as dementia and sequelae of stroke. These narratives were accompanied by suppressed cries. According to the residents—and we witnessed some of these episodes—the matriarchs of the hill showed acute shortness of breath, fainting spells, and intense diffuse painful crises, generally triggered by violence. Our fieldwork evinced an understanding of depression as an experience of intense *physical–emotional* malaise that affects bodies and subjectivities in chronic conditions of abuse and violation of their integrity. This understanding demanded an approach to care that enacted this vision.

Clinical Encounters and "Impaired Lives"

Physicians and residents reported that, when challenged with patients with depressive experiences, such as Francisca and Nilda, they would practice what they called a "patient-centered clinical method." The method traditionally encompasses four components: exploring health, disease, and the illness experience; understanding the whole person; finding common ground; and strengthening the patient–doctor relationship (Stewart et al. 2014). Our fieldwork, however, identified some significant differences between that method and the main care practices offered to people with depressive symptoms. While constituting an important step to overcome mind–body dualism, the classical patient-centered clinical method focuses on psychological stress and changes in thoughts and feelings, corresponding to a more rational and monological conception of personhood, typical of Western psychotherapeutic approaches (Kirmayer 2007: 240). In addition to the person, the approach put into practice by the professionals in our research aimed at the life of each individual, the resumption or renewal of movements and connections that they associated with being alive. We want to highlight those local specificities using elements of a resident consultation as an illustration.

The "Three Stages"

We followed the consultation of Janaína, a 27-year-old Black woman. She had initially been diagnosed with hypertension and diabetes. In the previous year, she had had visual loss in her right eye and was diagnosed with glaucoma. Janaína was on the eve of undergoing a surgical procedure for that condition, and resident Jaime had requested preoperative exams for surgical risk. After seeing the test results, Jaime asked the patient: "And, how are things going?"

Janaína told Jaime about her aunt, who had dementia and lived with her. Janaína felt herself "reaching [her] limit" because her sick leave from work would end in a few days and she did not know how she would take care of her aunt. Besides, she was very afraid of losing sight in her left eye. The resident listened for a few minutes, and then he remarked that he noticed that she "was not well" and that it would be good if they could continue talking about what was going on with her. He gave Janaína some "homework" for the next appointment. He asked her to list on a paper "three good things [in her life] right now," "three bad things," and "three things [she was] learning." He explained:

> Putting it down on paper is a different exercise, sometimes we don't know why we are suffering. It helps organizing things. It helps to understand how we see ourselves. What you are experiencing is related to your moment of life. Everything you are doing is really important, [including] coming here to take care of yourself.

Janaína stressed that she felt a lot of guilt about her mother's death and that she did not want the same fate to befall her aunt. Jaime then proposed that they resume their conversation the following week, when she would bring her homework. When asked how he would describe the consultation, Jaime stated he had practiced "patient-centered medicine." He explained that this meant putting into practice three types of techniques: listening, "*vivencia de si*" (living or experiencing oneself), and "instrumentalization for improvement."

The three-stage sequence with which Jaime described his understanding of the patient-centered clinical method was reflected in the practice of other family physicians and residents. The first stage, listening, involved inviting the patient to describe not only what she experienced, or felt, but also what she believed could have triggered that feeling. The purpose was to encourage the patient to talk about herself, how she experienced and understood her situation. Hearing, listening, welcoming, and "provoking a reflection about oneself" were residents' first tasks when confronted with depressive suffering. They kept silent and used some gestures and postures: the attentive eye, the body turned toward the patient, hand-to-hand contact, or a hand on the shoulder. Open questions about family life, work, projects, and future dreams were also important tools. Patients described listening as a moment of "letting off steam" (*desabafo*). When asked by Jaime how he could help more, Nilda replied: "You already help me a lot. Just a way of letting off steam (desabafo). I know you're listening to me. I just have to thank you." There were frequent consultations focused only on this first stage, in which doctors and residents spoke little and kept to themselves so that patients, between tears and sighs, could narrate what was happening to them.

The second stage involved activities that produced the *oportunidade da pessoa se viver* (opportunity for the person to live or experience herself) or vivencia de si. While in listening the focus was on welcoming patients' manifestations, in this second stage, residents' verbal interventions and activities aimed at provoking patients' assessment of their own experience. This stimulus may occur through additional listening, as well as through questions and opinions, feedback, or homework like the one Jaime requested from Janaína. "Yeah, you can go back to what you used to be, even if you become something [different] later, but it should be a healthy passage," observed Jaime. Feedbacks and longer conversations in which physicians and residents presented their understanding of what was going on with their patients were a frequent resource in the second stage. During feedbacks, professionals tried to draw attention to progress or struggles in patient care that patients either did not value or failed to perceive.

On a morning of home visits on the hill, we accompanied family physician Marisa on her visit to Tânia, a 42-year-old Black woman, diagnosed with severe depression with recurrent thoughts of taking her own life and a suicide attempt two months earlier. Tânia stated that she was feeling better, that she no longer thought about killing herself. However, she wanted to reduce her medications as she was gaining weight. Marisa provided her with feedback and a suggestion:

> Tânia, first, I think it's important for us to realize how much you've achieved. In the first consultations, you just cried your eyes out. You also couldn't leave your room. It's hard now, but you're getting it. It's also important that you don't want to kill yourself anymore. The drugs do have some side effects, but it's not fluoxetine that's making you gain weight. We may have to discontinue or reduce clonazepam. If you stop taking fluoxetine, you won't be fine and there will be a setback. It took you almost two months to have a major improvement. Fluoxetine also takes a long time to make an effect. What about doing some physical activity? What do you think?

Tânia said that she felt agonizing back pain because of the "screw" she had in her spine and that this made her afraid of exercising. Marisa pointed out that moderate physical activity would not be an issue and suggested that Tânia could do water aerobics for free in a community project. Tânia was left to think about it and agreed for the moment to try and reduce the drug clonazepam.

The feedback delivered to Tânia shows how vivencia de si may involve suggestions for the next stage: "instrumentalization for improvement." This stage comprises activities that may promote patients' well-being and relief from suffering. Here, physicians and residents encouraged patients to join any group activity, whether religious, artistic (such as capoeira and rehearsals at the community's samba school), craftsmanship, folk dancing, or even meditation. Whenever patients refused to blend in groups, individual physical activities were recommended, such as: a walk on the community soccer fields, on a beach or in a park, exercising at home, or simply leaving home to visit a relative or friend. These activities were agreed on by professionals and patients. Often, patients had difficulty in defining a routine activity, and the patient-centered consultations filled this void. Through more frequent consultations, weekly or fortnightly, residents volunteered as a form of network for patients when they could not rely on family, friends, or community support. Being present and demonstrating to the patient that she could always count on her family physician constituted a valuable therapeutic action, especially for patients who suffered from loneliness and isolation. Professionals reported that more frequent consultations were effective in improving patients' depressive symptoms, but, at the same time, due to the large population served, they could not offer this form of care over a long period of time.

From Person to Life

The three stages identified in the residents' consultations differ from the theoretical presentation of the patient-centered clinical method in two main and interrelated ways. First, although the patient-centered clinical method starts from a complementary approach to health, disease, and the illness experience, disease and illness are normally seen as distinct phenomena (Stewart et al. 2014). Our interlocutors, however, did not describe depression as having separate biological and psychosocial aspects. Family physician Marisa observed that depression comes from a human life that has undergone cumulative episodes of suffering that, at a given moment, harm a person's relationships, representations of herself, her own body, and even her "substances." As a result, the professionals with whom we worked did not provide separate treatments for the biological and psychosocial aspects of the condition. The three stages method took an "obviation approach" (Ingold 1998), as an alternative to the complementarity of the patient-centered clinical method. An obviation approach aims to dissolve the divisions between biological, psychological, and social aspects of human beings and to understand the person, or rather the "organism–person" as "singular locus of creative growth within a continually unfolding field of relationships" (Ingold 1998: 23).

Second, in the patient-centered clinical method, exploration of the patients' experience normally focuses on psychological stress and changes in thoughts and feelings, corresponding to a more rational and monological conception of personhood, typical of Western psychotherapeutic approaches (Kirmayer 2007: 240). By contrast, the three stages had a more practical, "enacted" emphasis (Mol 2002). The questions posed in the first and second stages were especially aimed at understanding patients' daily practices: what they liked doing in their everyday lives, why they stopped doing one activity or another, and what they would like to do differently. The third stage involved experiencing some change in a concrete way, preferably by participating in groups. Although they enabled a space for listening and reflection, family physicians and residents understood that care for depression involved changes in the patients' network of relationships. Unlike standard individualized rational care, in this approach, exploring and reconstructing the patients' network of relationships constituted the central element for the care of people with depressive symptoms.

Patient-centered consultations therefore call for an analytical approach that stakes out an alternative to the nature/culture and mind/body dualisms that largely underlie medical and psychological approaches to mental illness. Brazilian anthropology has produced important research exploring tensions in mental health care between scientific, biomedical, and psychological knowledge and practices. Based on ethnographic research carried out with urban Brazilian workers in the 1980s and 1990s, Luiz Fernando Duarte (1986, 1997) proposed the use of the category of "physical–moral disturbances" (*perturbações físico-morais*) to describe the experience of *nervos* (nerves) and *nervoso* (nervous), the preferred local idioms of distress in these populations. Physical–moral disturbances, he argued, are "conditions, situations or life events considered irregular or abnormal by social subjects and that involve or affect not only their most immediate corporeality, but also their moral life, feelings and self-representation" (Duarte 2003: 177).

Duarte argued that nervos and other forms of subjectivation in Brazilian lower classes did not follow the "ideology of individualism" of modern Western culture (Dumont 1992), marked by a strong opposition between mind and body, spirit and matter. For that reason, nervos was not adequately described and interpreted with categories such as mental illness or psychosocial distress (Duarte 1994: 84, 85). For Duarte, "the culture of the urban lower classes is 'hierarchical' or 'holistic' as opposed to the 'individualism' that prevailed within middle and upper classes'" (Duarte 1986: 58). Problematization of nervos and nervoso in the 1980s accompanied criticism of the efficacy of psychoanalytic theories and mental health care for that population (Costa 1989). Local idioms of distress like *doença de nervos* (nervous disease) and nervoso were experienced by those individuals as fundamentally bodily phenomena. Nevertheless, many of those who suffered from these conditions were subject to attempts to locate them in their individual psyches, resulting in the "psychologization" not only of the experience of nervos, but also of the social, political, and economic problems they faced. Meanwhile, under the care of biomedical practitioners, experiences like nervos would end up being attributed to a bodily disorder (Duarte 2003: 177). For Duarte, to overcome the psychologism/physicalism division, anthropological research should focus on the person or personalization (i.e., the totality and singularity of the patient and his or her experiences) (Duarte 2003: 178).

Likewise, Ingold criticizes anthropological investigations oriented to the "very meaning of the human" detached from world, matter, and things. Anthropology must understand human beings not for what they *are*, but for how they *live*. The focus on how human beings *live*, rather than on theoretical definitions of what human beings *are* or should *be*, corresponds to the practical emphasis of three-stage patient-centered medicine exercised by Brazilian professionals. Ingold adds that humans not only live, but lead their lives (Ingold 2018: 20). Lead should not be understood in the sense of transmission, as putting into practice a preconceived model of what life should be. What produces the difference between living and leading life is attention. Attention, for Ingold, involves a shift from a self-centered concern to the focus on one's surroundings, other people, materials, and on the relationships that are established with them (Ingold 2018). In an attentive posture, we "expose ourselves" to the world, to transform ourselves with it (Ingold 2018: 30). As an illustration, when Jaime assigned homework to Janaína, he asked her to pay *attention* to her experience. At the next consultation, Janaína commented on her experience of answering the resident's questions at home: "It gave me a feeling of relief. I'll see if I get used to doing some writing in the evening." She brought a paper with notes about her reflections, noting that she perceived herself as distant from her children and that she wanted to do something to get closer to them.

Family medicine professionals in our research promoted an "education of attention" (Ingold 2001) with their patients. The patient-centered clinical method exercised by family physicians and residents created conditions for patients to listen to themselves and reflect on their life trajectories. Attention was experienced through silence, questions about the relationship between patients' suffering and their life story, and the exploration of experiences that produce pleasure and well-being. Patients were invited to discover new ways to go on with their lives. Listening, vivência de si (living or experiencing oneself), and "instrumentalization" are exercises in cultivating attention to reinhabit the world and discover what to do with their own lives. Nilda found in the care of her granddaughters, in her daughters' support, and in more regular walks in the neighborhood square, a way to protect herself at times when her husband would go through a relapse in drug abuse. The family physician referred Tânia to a specialized public mental health service where she started psychotherapy. She felt that it was not the time to go back to work. Moreover, she wanted to help her husband stop drinking. Janaína was preparing for a conversation with her children, as an attempt to improve her relationship with them. These were not radical changes, but possible and yet difficult ones for such women at that time. Regular consultations with physicians and residents provided a space to "let off steam" and find support for these changes, and to continue living.

The question that patient-centered consultations sought to answer was ultimately: What makes life flow? The answer would always be unique for each subject. There were no pre-formatted therapeutics for suffering experiences. Therapy entailed a "guided rediscovery" (Ingold 2001: 138, 141) of qualities and powers of being alive, mediated by residents' questions to patients.

The Role of Medication and Patient Groups

In addition to the consultations, the use of two other therapeutic resources elucidates the obviation character of the three-stage approach to depressive symptoms in our fieldwork: the role of medication and patient groups at the health facility, used in "instrumentalization for improvement."

Family physicians and residents embraced a critical stance against biological reductionism but did not take a radical position against diagnostic classifications such as the International Classification of Diseases of the World Health Organization (2020). Their therapeutic focus on life, groups, networks, and relationships arose from the attempt to respond to the care demands of the assisted population that would avoid pre-established labels, such as depression or mental disorder, even if those labels might be occasionally used when patients described themselves as having one or more specific diagnoses. Although these professionals tried to manage depression without prescribing medication, antidepressant prescription was intended to be symptomatic, enabling patients to go on with their life projects (Moncrieff 2018).

Prescription of antidepressants—basically fluoxetine and amitriptyline, available for free at the health unit pharmacy—was also part of the third stage. However, prescription played an auxiliary role in alleviating the symptoms of depression, facilitating the resumption of patients' activities. During the consultations, family physicians and residents explained that drugs only functioned as a support. To explain this, they used several metaphors. For example, medication was a "ladder to get out of a hole," a "coat for going out in the cold," a "crutch for walking." They emphasized, however, that antidepressants would not replace the patients' own role in making the necessary changes in their lives to improve their depressive condition. "It's a coat for going out in the cold, but it won't go out for you, you're the one who has to go out," explained family physician Marisa.

Prescription and use of psychotropic drugs—or their rejection—in mental health care, as Béhague (2015) has argued, do not result from a simple rational and instrumental adherence to a certain explanatory model of mental suffering (whether biopsychiatric, psychodynamic, or psychosocial). Such narratives and practices are immersed in "the broader moral, social, structural, and economic contingencies that drive (or circumvent) pharmaceuticalization" (Béhague 2015: 321). In Béhague's ethnographic investigation in Pelotas, in the south of Brazil, psychodynamic-oriented psychiatrists' criticism of an explanatory model of "bioepistemic authority" opened space for a potential rise in the prescription of psychotropic medication as "social anesthetics," in the frequent situations of therapeutic failure of a psychodynamic approach to experiences of mental suffering (Béhague 2015:327).

In patient-centered consultations, family physicians and residents spoke with patients about returning to pleasant activities that they had abandoned or starting new activities, such as exercising. They also encouraged patient participation in unit groups—dance, body awareness, handicrafts, and mental health discussions—as well as in associations, public facilities available in the neighborhood, such as nursing homes for the elderly. Family physicians and residents defined this practice as "creating a network for patients." Being in a network was a highly valued care and patient support strategy.

"Unit groups" were an important strategy for doctors and residents to provide care for patients' suffering experiences of wide intersectional determination (Perry 2020). A significant example was the creation of a mutual support group for women with incarcerated family members, some of whom we accompanied in medical consultations for depressive symptoms. In this group, women could talk about their emotional struggles and difficulties accessing social protection resources for themselves and their imprisoned relatives. They could also think together about ways to deal with these difficulties. One of the strategies raised within the group was writing together, women from the hill and physicians, and posting on social media a "reflective letter to the population." In that letter, they pointed out several structural elements of incarceration in Brazil, such as the fact that "more than 60% of prisoners were black, young and poor." The letter concluded by stating that "the system is designed in such a way that the prisoner returns to prison after being released. This is our everyday life. We think about it every day. And, have you ever thought about it?"

Making a network was a way to overcome social isolation. For Ingold, the *environment* is not a network of interconnected points, but a "meshwork," a living and growing texture (Ingold 2010). People and things are not self-contained objects that occupy a "pre-prepared" world. As in a meshwork, people and things are alive in their own environment like knots “whose constituent threads, far from being contained within it, trail beyond, only to become caught with other threads in other knots” (Ingold 2010: 4). These threads should not be seen as “lines of interaction,” but as flows or “lines of growth and movement.” People and things live along these fluxes. Away from these flows, they are dead (Ingold 2010: 7).

This interpretation coincides with the idea that, in depression, individuals are “half dead” due to social isolation. Having a network was thus a protective factor for the development of depression. To be in a network is to be alive, to produce dialogues and perceptions about one’s own experience and thereby to become capable of reconfiguring it. Groups at the health care unit promoted the formation of such networks.

A Reparative Guilt

Anthropological research in mental health in Brazil (Biehl 2005; Nunes and Torrenté 2013) stresses the social, political, religious, and public health care elements that permeate trajectories of people with severe mental disorders in contexts defined by precariousness and structural violence. We have argued elsewhere (Ortega and Wenceslau 2020) that cultural aspects of mental healthcare are concealed within mental health services in the country—a process that we called the “silencing of culture.” This erasure and internal contestation is related to the imaginary national narrative of “cultural uniformity”[5] in Brazil. This understanding has influenced mental health policies and the organization of services, which have privileged class stratification and socioeconomic inequality at the expense of cultural diversity. Our fieldwork evinced professionals’ attempt to develop a more attuned approach to the “world making” (Biehl 2016) of their patients with depressive symptoms.

Our research within family health strategy in Brazil points to great hurdles in the delivery of mental health care. Health services involve an increasing number of patients with experiences of distress and helplessness, who are often at risk of self- or heteroaggression. A majority of the population targeted by the FHS lives in conditions of poverty and structural violence—conditions that are inseparable from their experiences of suffering. Few psychiatrists and psychologists are available to support primary health care, and there is a lack of adequate professional training for primary care. Finally, we note the exhaustion of professionals who continuously deal with patients’ social suffering in contexts of state neglect (Pereira et al. 2020; Wenceslau and Ortega 2015).

Even amid these adversities, professionals in our research deployed alternatives, striving to offer a form of mental health care that engaged with life. Our investigation reflects what Béhague and MacLeish (2020), drawing on the work of Sedgwick (2003), call “reparative ethnographies.” Building on Melanie Klein’s psychoanalytic theory, Sedgwick defined as “reparative” a “position” that can “repair” or “assemble” painful psychic experiences “into a whole,” finding paths to provide “nourishment” and “comfort” through one’s own pain (Sedgwick 2003: 128). From a reparative stance “the psyche appears as unfinished, in progress, contingent, in danger of expiration, or an emergent form that welcomes new approaches” (Béhague and MacLeish 2020: 16). “Harm, change, help, progress, and destruction" (p. 16) take place at the same time and are frequently assembled together in our lives. Hence, reparative approaches are appropriate to investigate local care practices "without falling into the traps of reductionism, false consciousness, the erasure of diversity, amplifying polarizations, or unattainable utopic imaginations" (Béhague and MacLeish 2020: 17). This reparative ethnographic perspective can support reflection on the reparative potential of the mental health care strategies implemented by physicians and residents in our fieldwork.

Resident Jaime portrayed his motivation for working with vulnerable communities as a "positive fault," conveying his aspiration to repair the structural violence suffered by his patients. He described his work as motivated by the possibility of distributing to the poorest and most marginalized individuals in society some of the benefits that he was able to enjoy as a privileged person who is young, White, raised in a middle-class family, and studied medicine at a public university. His social status generated an experience of discomfort, even guilt. He gave vent to his guilt working as a family doctor for the hill population and using his work to "cherish the lives" of the excluded and marginalized. According to Jaime, "guilt, in fact, it is a positive guilt, it is an engine. I have this commitment because I am privileged. That's it; I will use my privilege to cherish the lives of others." For family physician Marisa, the "physical and emotional burden" of her work is gratifying. "It is very good to see that there are people in whose lives I have made a difference," she told us.

It was hard to assess the extent to which residents and physicians contributed to promote reparative experiences among patients. Our observation of patient-centered consultations with 22 patients indicates that there was no final outcome or cure, but cyclical periods of improvement and worsening of depressive symptoms. Although sustained improvement did not always occur, 19 out of the 22 patients acknowledged the role of family physicians and residents and welcomed their attention, listening, words, and advice. When asked what else had contributed to his improvement, João, a 67-year-old White *nordestino*,[6] cited "their presence [of doctors and residents] and kind words." A lack of "therapeutic closure" often accompanies a reparative position (Béhague and MacLeish 2020: 16). Family physicians and residents did not look for definite outcomes. Consultations were often short, lasting 10 or 15 minutes, and several issues remained to be assessed or discussed. Family physicians and residents believed that patients' suffering did not demand a solution, a closure. Rather, it required a presence, a testimony, a companion in crossing the dark paths of life. In this regard, an additional convergence between Ingold's approach and care may be established. Anthropology is always an open practice and does not provide final answers or solutions to human life's challenges and dilemmas. "The point about anthropology," writes Ingold, "is not that it should end in final outcomes but that it should open up to experiences that themselves open to further experience, making possible a never-ending and always beginning process of growth and discovery" (Ingold 2018: 65). The "embrace of uncertainty" however, does not prevent the possibility of exploring new trails and new ways of walking.

Conclusion

In Rio de Janeiro, care practices for individuals with depressive symptoms offered by family medicine physicians and residents were an exercise in reengagement with life.

Mental health professionals centered the category of life through a sequence of three stages that we described with the local idioms of listening, vivência de si (living or experiencing oneself), and instrumentalization for improvement. The clinical method used by the family physicians and residents participating in this research involved principles and objectives that are attuned with Ingold's concept of "education of attention." The three stages provided patients with orientations to discover new ways of being alive through an open and receptive exploration of bodily, artistic, and social practices. Groups and collective activities may be interpreted as "meshwork" in Ingold's sense. These collective activities enabled patients to build new relationships, feel part of that community, and assume new commitments and goals according to the purpose of each group. These experiences opened new paths for moving on with their "impaired lives."

Taken together, these practices offer an alternative to the "biologization of the mental"/"sociologization of suffering" binary (Silva 2013) prevailing in several interpretative models of mental illness (Cooper 2016; White and Sashidharan 2014). The category of life articulates different possibilities of intervention—medical consultations, group activities, medication—insofar as these therapeutic resources were made available as part of the process of reengagement with life. Patients', family physicians', and residents' discourses and practices did not dissociate biological and psychosocial aspects of human suffering.

Our study enabled us to follow professionals' and patients' reconfiguration of categories and diagnostic concepts to embrace the differences and complexities of the human condition. Such a reparative attitude should be integrated into public mental health care practices, not only as one of its components, but as an ethical and epistemological commitment. The invisibility of patients' experiences of suffering and the inconsistencies of standardized classifications of mental distress have facilitated the naturalization of polarized approaches to mental illness. These approaches may intensify and prolong the suffering of individuals, population groups, and social strata whose experiences are not recognized or are distorted and fragmented. As the general practitioner and writer Iona Heath (2017) points out, we must assume that one of the main challenges in the field of public health is not to reduce our thinking and care practices to rules and standardizations, manuals, and protocols. Therefore, it is essential to restore the place of persons and lives in health practices.

Acknowledgments. The authors would like to thank the journal's editor, Alex Nading, and two anonymous reviewers for detailed and helpful comments on earlier versions of this article.

Notes

1. In addition to the criticism of individualist assumptions of clinical practices, Duarte criticizes North American medical anthropology, especially the research carried out during the 1980s on nervous disturbances (*perturbações nervosas*). He claims that North American medical anthropology, in its theoretical method, "accepts the terms in which Western medical ideology poses the question," by focusing on demonstrating the "culturally determined" character of the manifestations

of "nervous disturbances," and not relativizing the arbitrariness of the interpretive assumptions of medical categories (Duarte 1993: 50).

2. For an excellent overview on recent anthropological explorations in the investigation of life and the "multiple forms in which human societies generate understanding of life that comes from their varied experiences of how living and dying have been transformed in our contemporary conditions," see Das's and Han's edited compendium *Living and Dying in the Contemporary World* (2016: 1). The editors' "concept note" provides an insightful theoretical conceptualization of the notion of life in philosophy and anthropology.

3. We found only one ethnographic study on depression within public primary health care (Family Health Strategy) in Brazil, and interestingly, it does not focus on the role of family physicians, but of psychiatrists, although it shows the emergence of local understandings of the category of depression (Martin et al. 2007).

4. All the names used are pseudonyms.

5. "Cultural uniformity," explains anthropologist Darcy Ribeiro (2000), is the most important consequence of the formation process of the Brazilian people as an ethnically homogeneous nation, a national ethnicity. Cultural uniformity is a controversial notion that helps us understand why ethnic and racial issues are historically downplayed in the country. Cultural determinants are actively neglected in the mental health field by local practitioners and policymakers. Cultural differences do not constitute a relevant level of engagement among service users (Ortega and Wenceslau 2020).

6. From Brazil's poor Northeast. The construction of the *nordestino* "Other" resulted from centuries of racial, cultural, and socioeconomic prejudice that has produced a regional identity and the collective category of the nordestino as a "minority group characterized by backwardness, poverty, and laziness." Thus, poor nordestinos are mistreated, exploited, and stigmatized in many southern Brazilian cities (Serrao 2020: 4).

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