The “cultures” of Global Mental Health: A case study on the ontologization of the concept of culture

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Abstract: The role of anthropology within health sciences has been an issue of intense academic debates since the origins of that discipline. Anthropology is frequently attributed the study of cultural aspects of health, disease and care. However, this solution faces several problems of theoretical foundation and of applicability in empirical studies. In this article, as a case study of the problems produced by defining culture and cultural elements as a “discretable” component of health/disease phenomena, we analyse the ways in which the culture concept is deployed in Global Mental Health literature. Global Mental Health (GMH) is a field of study, research and practice that addresses issues involved in the expansion of universal and equitable mental health care to all populations on the planet. Both critics and GMH advocates assume an ontological separation between "nature" and "culture" to typify mental illness, linking it predominantly to one or other of these two categories. As an alternative, we propose a different theoretical approach to the social issues involved in the expansion of international public health care in mental health: Arthur Kleinman and Didier Fassin’s moral anthropological approaches. Both anthropological projects exhibit methodological differences and divergences of objectives. Still, by taking "moral" questions and objects as the focus of their research and diverting from "culture", they offer possibilities to the theoretical grounding of social research within GMH. We discuss some limits of this alternative and highlight some potential specific contributions of this approach especially in contexts, such as Brazilian urban scenarios, in which we observe a "silencing of culture" within the field of mental health care.

Keywords: Culture; Global Mental Health; mental illness; moral anthropology; ontology

Introduction

The role of the social sciences, and more specifically anthropology, in the interface with the health sciences - especially medicine and public health - has been the subject of intense academic debate throughout the twentieth century. The debate continues in current times and exhibits new configurations (Alexandrakis, 2001; Rose, 2013; Stellmach et al., 2018). A crucial issue in these disputes involves the definition of the scope and object of anthropology within the health sciences.

What are the phenomena medical anthropology should address? How to distinguish - or not - these phenomena from those that are investigated by the biological sciences? A recurrent and often naturalized answer of those questions is the relegation of anthropology to the study of the *cultural aspects* of health, illness and forms of care. This response is based on the recognition of culture as a universal abstract concept, and of various cultures as concrete expressions of this concept, taken as evident and consensual assumptions. It would be the task of anthropology to study cultures and cultural aspects of health and disease, and, if possible, to point out appropriate ways to engage with them. However, the emphasis on culture and cultural differences as the main object of anthropology ignores an extensive debate within the discipline itself that questions precisely the essentialized, ontological use of the category culture.

The culture concept is notoriously slippery and prone to reductionism when put into practice in diverse fields of medicine, the neurosciences and public health. Therefore, it has been submitted to deep scrutiny by social scientists, anthropologists, science and technology scholars, and philosophers. Some scholars, like anthropologist Didier Fassin, criticized what he dubbed "culturalism", i.e. the overdetermination of cultural over socioeconomic factors in public and mental health, ethnopsychiatry, global health and humanitarian reason. Culturalism depolitizes its subjects, essentializes cultural differences, understands socioeconomic inequalities as cultural differences and neutralizes critical thinking (Fassin, 2001; 2004a; 2006; 2012a, 2017; Fassin & Rechtman, 2005). The essentialization of culture has also been critically examined in fields like cultural neuroscience which promotes two-way collaborations between the neurosciences and anthropology to examine the brain's "enculturation", i.e., how culture is cerebrally "inscribed (Downey and Lende 2012). However, despite the claims of brain-culture bidirectionality cultural neuroscience frequently presupposes a belief in the ontological primacy of the brain. It thereby participates in the processes whereby differences are constructed and culture essentialized and ontologized (Vidal and Ortega, 2017, 2018).

Even leaving aside its meanings when used outside professional anthropology, such as when Hannah Arendt spoke in the early 1960s of “the crisis in culture” or when half a century later Zygmunt Bauman wrote of “culture in a liquid modern world,” the concept of culture is notoriously malleable (Kuper 1999; Eagleton 2000). In *Primitive Culture*, Edward Tylor (1871, 1) defined “Culture or Civilization” as “that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.” Since then, many others followed more or less his lead, seeing in culture “the complex of values, customs, beliefs and practices which constitute the way of life of a specific group” (Eagleton 2000, 34). Different emphases are also to be found, with a range and overlap of meanings, as illustrated in Raymond Williams’ (1985, 91) observation that “in archaeology and in cultural anthropology the

reference to culture or a culture is primarily to material production, while in history and cultural studies the reference is primarily to signifying or symbolic systems."

Anthropologists Alfred Kroeber and Clyde Kluckhohn (1952) enumerated over 150 definitions of culture, which they classified into different types: descriptive, historical, normative, psychological, structural and genetic (in the sense of developmental). In addition, they identified the numerous elements that went into them, from acts and activities to feelings, languages and traditions (see also Shweder 1991). Two things emerge from that variety. One is that students of culture tend to characterize their object as "the organization of human experience and action by symbolic means" (Sahlins 2000, 158). The other is that those organizations and means are neither static nor form systematic and homogenous totalities. Early twentieth-century anthropologists sometimes regarded culture in that way, producing what Marshall Sahlins (ib., 159) critically called "anthropology-cultures." In that framework, it was always possible to identify the authentic native who perfectly embodied the culture. Indeed, as James Clifford (1988, 338) noted, the very idea of culture "carries with it an expectation of roots, of a stable, territorialized existence."

Such view of cultures as integrated coherent totalities, static and homogenous probably never existed, and if they did, they certainly no longer do in the context of "locally lived lives in a globally interconnected world" (Gupta and Ferguson 1992, 11). Cultures are rather characterized by internal contradiction, and anthropologists have long abandoned the idea "that everything in a society must adhere to a single configuration or pattern," no longer thinking of culture as a "single integrated reality" (Scheper-Hughes, 1984, 90, 91). Other anthropologists are more radical and propose to get rid of the concept of culture altogether. Since culture is shadowed by coherence, timelessness and discreteness, and is one of the main mechanisms to enforce inequality and freeze difference, anthropologists should deploy strategies for "writing against culture" (Abu-Lughod, 1991).

In this article we examine the dispute between advocates and critics of Global Mental Health (GMH) around the concept of culture. GMH is a "new" field of public health research and practices that proposes the expansion of mental health care to all populations on the planet, especially the poorest and historically deprived of health care (Patel, 2012). After examining some of the arguments of GMH advocates and critics, we propose a different contribution of anthropology to broaden the understanding of epistemic and social dilemmas that emerge in this "new" field of public health, taking as main references the moral anthropology of Arthur Kleinman and Didier Fassin.

Culture, psychiatry and the Global Mental Health agenda

Until the early 2000s, the term "global mental health" was used in academic circles primarily to describe the general state of mental health of a given population (Cohen et al., 2014). In 2007, the British journal *The Lancet* published a first series of articles on *Global Mental Health* bringing together a significant number of information on the worldwide mental health situation and the severe impact of mental health disorders in population health across the globe (Prince et al., 2007; Jacob et al., 2007). These studies also postulated the broad use of evidence-based treatment packages for the most prevalent mental disorders (Patel et al., 2007). The last of the articles in the series, "A Call for Action" (Lancet Mental Health Group, 2007), was an invitation to mobilize the international community for investment, research, interventions and policies in mental health with the goal of an urgent overcoming of the so-called "treatment gap". These studies also pointed out that the lack of access to adequate treatment constitutes a violation of the human rights of people suffering from mental disorders, and that the weight of cultural and social factors in the diagnosis and treatment of these conditions requires the qualification of the interventions to be tested or implemented (Patel, 2014).

Shortly after the emergence of this proposal, the first caveats (Bass et al., 2007) and more convincing critiques arose (Summerfield, 2008). Although presented as a multidisciplinary field by their proponents (Patel, 2014), critics of GMH (e.g. Fernando, 2014; Summerfield, 2012) argue that its theory and practice are largely guided by Western psychiatry principles and interventions, based on the psychopathological approach of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatry Association (DSM-5, APA, 2013) and the *International Classification of Diseases and Related Health Problems* of the World Health Organization (ICD-11, WHO, 2018). To ground this and other critiques directed to GMH, the insignia of "culture" frequently is used as a marker of these positions, contributing to form what Kirmayer and Pedersen (2014) have broadly termed the "cultural critique" of Global Mental Health. According to these authors, an important part of GMH critique emphasizes "the difficulties and potential dangers of applying Western categories, concepts, and interventions given the ways that culture shapes illness experience" (Kirmayer and Pedersen 2014: 759).

Cultural issues had already an important place in mental health disciplines that historically preceded the emergence of Global Mental Health. Throughout the twentieth century, disciplines such as comparative, cultural and transcultural psychiatry have sheltered the academic debate surrounding the extension of the use of modern psychiatric categories and therapies for the medical treatment of non-Western populations and the potential "cultural" aspects involved in this process (Jenkins, 2007). According to Kirmayer (2007), the field of cultural or transcultural psychiatry

concerns the work of clinicians and researchers to examine and intervene on subjective behaviors and narratives of non-Western populations, which are interpreted as mental illness, considering precisely "cultural" elements of this process. In the first half of the twentieth century, cultural psychiatry was largely identified with "colonial" comparative psychiatry, and conducted many studies "focused on the exotic in order to examine the universality of major psychiatric disorders" (Kirmayer, 2007: 6). Its main purpose was to search for evidence of non-culturally shaped aspects of mental illness, whose identification would allow the introduction of the same categories and diagnostic methods in different cultural and social contexts.

However, in contrast to this perspective, the proposal of a "new" transcultural psychiatry (Kleinman, 1977) emerged during the 1970s and 1980s, having as one of its main references the work of the American psychiatrist and anthropologist Arthur Kleinman. From ethnographic studies on "somatic" presentations of depression in China, Kleinman (1977, 1986, 1987) proposed that mental disorders could not be conceived apart from their cultural milieu. Even the presence of similarities between populations could not diminish the relevance of culturally specific components in local definitions of conditions that bear some level of correspondence with Western mental disorders. According to this "new" perspective, cultural psychiatry should assume that disorders that at some level correspond or dialogue with psychiatric diagnoses in Western medicine are particular to each sociocultural context, and that as or more important than mapping the similarities is to research these specificities. Kleinmann's "new transcultural psychiatry", that has influenced the medical anthropological movement of the 1980s and 1990s, "questioned the universality of psychiatric constructs [of depression] claiming that different ways of understanding body and self could give rise to fundamental differences in psychopathology" (Kirmayer, 2006: 1277).

For Kirmayer, the "new transcultural psychiatry" and its ramifications in anthropological research in mental health, while reinvigorating and reorienting cultural psychiatry as a discipline, failed to prevent the growth and consolidation of a "portability" of western psychiatric theory and practice as the basis for international mental health care proposals (Kirmayer, 2006: 128). As a recent and significant example that endorses Kirmayer's claim, although the fifth and last edition of DSM-5 (APA, 2013) leaves some room for remarks on "cultural" specificities of mental disorders, it describes its role primarily as a "modeling" of discrete diagnostic entities (Ecks, 2016). DSM-5 states that "mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that *shape* the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis" (our emphasis, APA, 2013: 14). The recent WHO version of ICD (ICD-11, 2018) largely repeats the same strategy, seeking to incorporate into each of its pre-established diagnostic categories what Read et al. (2019: 5) describe as "culture-related information based on a review of the literature on *cultural influences on*

psychopathology and its expression for each ICD-11 diagnostic grouping" (our emphasis). DSM and ICD are the main references for clinical practice in psychiatry in the world, and although they present small differences in diagnostic definitions, they follow the same "diffuse" system (Stein et al., 2013) of phenomenological classification of mental disorders by grouping of behavioral and subjective symptoms.

Considering this historical context, a renewed field for debates on the relationship between psychiatry and culture was most recently driven by the Global Mental Health agenda. GMH scholars have sought to take a nuanced position in this debate (Patel, 2014; Kohrt and Mendenhall, 2015). Their theoretical assumptions and research questions aim to reconcile the understanding of culture as a relevant modulator of mental disorders that participates in the production of the various possibilities of illness presentations for the same mental disorders (Patel, 2014). For GMH advocates, this important role of culture does not preclude a cross-sectional recognition of psychiatric conditions around the world, but makes it more complex by requiring in-depth ethnographic studies to establish equivalences with the already established diagnoses (Kohrt et al., 2014). Within this "cultural" scope, political, economic and social aspects that influence the access of people to mental health care, whether traditional and/or biomedical, are also examined (Kohrt and Mendenhall, 2015).

As a consequence, some anthropologists have conducted ethnographic studies in collaboration with Global Mental Health researchers in order to provide subsidies and guidelines for the global expansion of mental health care, especially in low- and middle-income countries (Haroz et al., 2016, Kohrt et al., 2014). Kohrt et al. (2016) have called for anthropological theories and methods to contribute empirical information to the advance of GMH, with an emphasis on research into diagnostic labels, idioms of distress and ethnopsychology to be incorporated into mental health interventions. They also promote research into the ways psychiatric treatments have been integrated and affected patients' daily lives.

The "cultural critique" of Global Mental Health

Although GMH research and interventions recognize the importance of cultural aspects in mental health care, several of its critics consider this recognition insufficient or even harmful. According to this GMH critics, the diagnostic-therapeutic model of mental disorders proposed by Western psychiatry would be a form of "cultural imperialism" (Bracken et al., 2016, Fernando, 2014; Miller, 2014, Summerfield, 2012, White, 2014). To back this assumption, those authors cite diverse studies that demonstrate that there are no biological markers that justify qualifying the various presentations of mental illness as organic disorders that could be handled with standardized

"treatment packages" across the world (Cox and Webb, 2015; Nestler et al. 2002; Wyatt and Midkiff, 2006).

In fact, both advocates and critics of western psychiatric diagnostic model and of GMH itself assess that the syndromic or clusters of symptoms approach, which has substantiated the latest editions of both DSM and ICD, has found no specific biological correlates that are able to distinguish people who suffer from these disorders or not (Insel et al., 2010; Patel, 2013; Gureje and Stein, 2014; White and Sashidharan, 2014). Advocates and critics differ, however, as to the paths that must be followed in the face of this lacuna of diagnostic validity. Pro-GMH authors (Gureje and Stein, 2014; Patel, 2013), estimate that, like other organic diseases, the discovery of biological markers for the main mental disorders would be a matter of time or adjustment of methods. Critics point out that potential biological correlations are elusive and social, cultural, and economic factors are the main determinants of both the definition and characterization of these disorders and their intensity and prevalence within different social groups and populations (Mills and Fernando, 2014; Mills and White, 2017).

According to Kirmayer and Pedersen (2014), the cultural critique of GMH questions the view of mental health problems essentially as “biologically determined entities with stable features, course and outcome” (Kirmayer and Pedersen 2014:760). We would go further and say that mental disorders are understood by several GMH critics as mainly culturally defined (Bracken et al., 2016; Summerfield, 2008, 2012). Therefore, they claim that the political imposition of one cultural matrix on another is at first reprehensible and constitutes a form of cultural imperialism (Miller, 2014). As a cultural phenomenon, each culture would have its own references on how to identify and care for people who present experiences and behaviors that limit their social life and produce malaise, maladaptation and negative subjective states (Snodgrass et al., 2017). The use of "diagnostic systems that are not appropriate for local cultural contexts" may lead to misdiagnosis and expose individuals to treatments of uncertain value (Kirmayer and Pedersen 2014: 764; see also Davar, 2014; Sood, 2016). Western psychiatry itself would be an example of this process - a Western ethnomedicine - and its applicability should be limited to Western or predominantly Westernized populations, without neglecting various questions involving the efficacy of its methods and the validity of its results even in these populations (Summerfield, 2008; Read et al., 2016).

The cultural critique of Global Mental Health is closely related to what we can define as the 'culture of GMH'. The culture of GMH (which largely reproduces the culture of global health) is shaped by the production of metrics as the best solution for central global health problems. Metrics are linked to what Vincanne Adams has called the "micropractices of liberalism" which "work seamlessly with the political aspirations of neoliberal reforms" (Adams 2016, 38), for they interrupt and frequently replace practices of governance and reduce complex health problems to problems of

counting. Health care priorities are defined by cost-effectiveness logics and business management models. This rationality corresponds to the decline of the relevance and insufficient funding of international organisations, especially WHO and the rise of philantrocapitalism, which turned business-oriented institutions like the World Bank and the Gates Foundation into major drivers of Global Health governance (Birn, 2014; Birn, Nervi and Siqueira 2016; Storeng and Behague 2017). Global health programs tend to turn all health problems into problems of economy, evinced in the growing presence of health economists in health planning, and the overarching pull of neoliberalism (Adams et al. 2019; McGoey, 2015; Sobo, 2016), a trend defined by Michelle Murphy as "economization of life" (Murphy, 2017). Under these regimes of "for-profit charity" technological and pharmaceutical interventions are favored over interventions that cannot show a profit or produce metrics accountability involved in marked-based problem solving of global health targets. Moreover, "without evidence of fiscal benefits, perfectly good health projects often get scrapped" (Adams et al. 2019; see also Kelly & McGoey, 2018). These elements of the culture of global health that defined the field as a social-economic-cultural world itself also characterize the culture of global mental health and are frequently invoked by critics of the field.

Old wine in new bottles for the biology vs culture debate

From the analysis of those arguments regarding the concept of culture, we observe that a significant part of the social theory applied to Global Mental Health, by both critics and advocates, reproduces the biology vs culture divide and advances an ontological (reifying, essentializing) use of culture. Biology and culture function as ontologies, in the sense of "orders of reality" (Schweder 2003), to which a given object or phenomenon - mental health issues in case - may alternatively belong, or be "hybrid," composed of elements that belong separately to these two ontological foundations.

When the labels “biological” and / or “cultural” are used in the debates, they are seldom accompanied by a clarification of the nature and scope of these categories. To biology are attributed the function and morphology of organs and tissues of the body, and more specifically of the brain, and the substances produced by them, which may or may not be affected in a uniform way in mental disorders. As for culture, some definitions are presented and there are not many differences between GMH critics and proponents at this point. We have already mentioned DSM 5 itself and, for comparative purposes, we indicate two definitions proposed by Kirmayer, referred to by critical authors of GMH (White, 2013). In the article “Beyond the cross-cultural psychiatry”, culture is defined as “a set of institutional settings, formal and informal practices, explicit and tacit rules, ways of making sense and presenting one’s experience in forms that will influence others”

(Kirmayer, 2006: 133). In another reference, Kirmayer points to a current and synthetic definition of culture as “a way of life” or “the values, customs, beliefs and practices that form a complex system. As such, culture encompasses all of the humanly constructed and transmitted aspects of the material and social world.” (Kirmayer, 2007: 5).

In the arguments of both, critics and advocates, a conceptualization of culture prevails as a system of meanings, rules and customs cultivated by human social groups. Just as in the case of cultural neuroscience, where claims to brain-culture bidirectionality frequently resulted in the ontological primacy of the brain, reducing culture to external element that shapes and influences neural activity (Vidal and Ortega 2017, 2018), GMH advocates conceive mental distress as a biological-cultural "hybrid" - with an ontological primacy of the first component, with the latter having a role of "modeling". On the other hand, critics question the value and comprehensiveness of the biological component, and understand these phenomena as fundamentally cultural. Thus, an interpretive binomial emerges that engenders the polarized debate between advocates and critics. When this epistemic operation is taken radically, biological or cultural classification directs the theoretical and empirical possibilities to different and also morally opposed paths. On the defenders’ side, failing to offer conventional and proven psychiatric treatment for people in mental distress is "a failure of humanity" (Patel et al., 2006). For critics of GMH, offering Western psychiatric treatments to populations suffering from poverty and the loss of their community and social referents is "cultural imperialism" (Summerfield, 2012).

Although the ontological divide nature/culture constitutes a recurring epistemic approach, we explore in this article other alternatives for the involvement of the social and human sciences with Global Mental Health research. It seems important to us to demonstrate that this divide is one theoretical and epistemic possibility among others. Its naturalization and uncritical reproduction within GMH debates, however, seems to us a frequent obstacle to promote social research in the field (Cooper, 2016). Other approaches may be useful in exploring questions that are not confined to the definition, identification, and interpretation of so-called cultural aspects of mental illness, irrespective of whether these aspects account only in part, as advocates claim, or entirely, as stated by critics, for those phenomena.

Among the intense debates around the academic scope of anthropological research itself (Ingold, 1996), there are several proposals for alternatives to the nature-culture dichotomy as the epistemic operation that grounds the discipline. From the classic critiques of British social anthropology to American cultural anthropology (Dianteill, 2012), through the various expressions of the contemporary "ontological turn" (Heywood, 2017), to the recent socio-anthropological research around "global assemblages" (Collier & Ong, 2005), "interdisciplinary entanglements" (Callard & Fitzgerald, 2015), "political biology" (Meloni, 2016) and "neurocultures" (Ortega and

Vidal, 2011; Vidal and Ortega, 2017) among others, we find a diversity of theoretical perspectives that highlight other subjects than culture as the focus of anthropology. In the next section, we analyze the contribution of two contemporary authors, Arthur Kleinman and Didier Fassin, who exemplify alternatives to the ontologization of culture as a way of contributing to the debates in GMH through their projects of moral anthropology.

Exploring a "moral turn" in GMH social research agenda

We are interested in examining convergences of Kleinman's and Fassin's projects of moral anthropology as a critique to the ontological use of culture within GMH debates. Before examining this issue, we should briefly address how they position themselves within these debates. Arthur Kleinman has been in favor of the main goals and strategies of GMH. He has been involved in academic research within this perspective, and justified his position on a moral imperative to respond to human rights violations faced by people with mental disorders worldwide, especially in the poorest and most vulnerable settings (Kleinman, 2009; Kleinman, 2013). Fassin, in turn, did not conduct specific research on GMH. However, in addition to his research on international medical humanitarianism and the expansion of psychiatric diagnoses involving the trauma category, he has published some articles that examine both the concept and the uses of Global Health, assuming what he calls a critical stance on this subject (Fassin, 2012a, 2015, 2017). In bringing some aspects of the intellectual path of these authors, we seek to understand how their epistemic and political positions were constructed and how they represent alternatives, albeit with divergent intentions, to the ontological presuppositions that permeate both the academic and political program and the cultural critique of Global Mental Health.

From his initial proposal of a "new transcultural psychiatry" between the 1970s and 1980s, from the 1990s onwards, Kleinman shifted the focus of his anthropology of mental health to what he came to designate as the study of the moral experience. That new focus led up to an anthropology of social suffering and an involvement with GMH in order to make the moral case for the mentally ill (Kleinman and Kleinman, J. 1991; Kleinman and Benson 2006; Kleinman, 2009; Patel et al., 2006).

Kleinman's early work (Kleinman 1977; Kleinman et al. 1978) could be situated within what we have designated as the ontological plane of the cultural critique of GMH. The main epistemic interest of that research was the description of indigenous interpretative categories of mental health distress among non-Western populations and their care practices, comparing them to Western psychiatry's diagnostic categories and treatment modalities.

Given the needs of his research contexts, Kleinman identified the insufficiency of this approach, especially the recurring use of the disease/illness dichotomy as a device for interpreting experiences of suffering. To address this gap, the American anthropologist proposes focusing on the experience of suffering through the interpretation of "what is at stake" (Kleinman and Kleinman, J. 1991: 277) for particular participants in particular situations. In this proposal for an ethnographic practice, the researcher is asked to inquire into local ethnopsychological conceptions, but as an intermediary, rather than final, objective. Identifying autochthonous conceptions offers a basis for understanding what is shared in diverse human conditions and in the tension between these conditions and individuals' lived experiences. Kleinman's anthropological project is that of an anthropology of subjectivity, directed at studying individual trajectories of change within the context of social transformations. Choosing the particularity of experience as the focus of analysis means moving as far away as possible from the idea of a universal human nature and producing an appreciation of the variety of human conditions in which diverse problems and discontentments are at stake (Kleinman and Fitz-Henry 2007: 55).

Didier Fassin refers to his anthropological practice as part of a project of a critical moral anthropology (Fassin, 2012b). He initially draws a distinction between his proposal and what he terms an anthropology of moralities, stating that the latter is restricted to the study of "local configurations of norms, values, and emotions" (Fassin, 2012b: 4). To Fassin, moral anthropology has a broader analytical scope and addresses "how moral questions are posed and addressed or, symmetrically, how nonmoral questions are rephrased as moral." (Fassin 2012b: 4).

Fassin proposes an anthropology capable of capturing the "impurities" of morals and moralities of contemporary societies, their tensions, contradictions and complexities. He exposes the ethical dilemma experienced by the social sciences, since their inception, between a descriptive and a prescriptive role, that is, of offering a more accurate understanding of social life or an agenda for improving society (Fassin [no date], 2005, 2009, 2012b). Curiously, Fassin does not only expose this dilemma, but instead of resolving it with an inevitably arbitrary position, disconnected from contemporary moral impasses, his analyses propose to consider the understanding/improving dichotomy, and other moral binomials, as research problems, exploring their ramifications in peoples' lives and their diverse social roles and territories. This position tends implicitly to resolve that dilemma with a posture that is, ultimately, more descriptive and critical. Fassin defends an epistemological rigor marked by a detachment from normative positions and moral and practical involvement that enables an objective analysis of moral and ethical questions. He emphasizes the acknowledgement of the nonexistence of a universal human moral grammar as a valuable, non-negotiable contribution of the social sciences to the understanding of social life.

In line with the critique to the ontological use of culture, Fassin scrutinizes what he names 'culturalism', i.e. the overrule of socioeconomic or sociopolitical explanations by the overdetermination of cultural factors (Fassin, 2001: 306). He extents the critique of culturalism to public health as a discipline that culturalizes its subjects, essentializes culture and interprets socioeconomic inequalities as cultural differences (Fassin 2004a). Moreover, ethnopsychiatry is also imbued with culturalism that results in neglect of the socioeconomic consequences of immigration (Fassin, 2005). The critique of culturalism is also shared by Kleinman, who opposes the anthropologization of distress and the creation of cultural archetypes out of the "always messy and uncertain details of a personal account of illness", thereby annihilating illness "from what is at stake for particular individuals in particular situations" (Kleinman and Kleinman, J., 1991: 280).

Still, there are important divergences among both anthropologists regarding especially the issues of social suffering and humanitarianism. Despite the convergence on the critique of culturalism, but diverging from Kleinman, Fassin expands that critique to the analysis of social suffering and humanitarian reason. For the French anthropologist the focus on social suffering, like on culturalism, depolitizes its subjects, individualizes complex sociopolitical situations and denotes the compassionate way of facing social and political problems (Fassin, 2006). Moreover, the anthropology of social suffering is permeated with a problematic "commitment to involvement", to "intervention" (Fassin, 2004b: 28) and constitutes an uncritical celebration of the role of "passion of compassion" in the public sphere. He also denounces humanitarianism for being an ideology used to legitimize morally dubious forms of political activity (Fassin, 2012c). Fassin criticizes medical anthropologists who became "global apostles of health" and have therefore blurred the "fine line between scientific detachment and moral involvement", which corresponds to the position of critique, to critical thinking (Fassin, 2012a: 116; see also Fassin, 2017).

Unlike Fassin, Arthur Kleinman not only defends an anthropology of social suffering and an "humanitarian social imaginary" to respond to human suffering, but promotes an approach to social inquiry that goes beyond the position of critique and engages in practical delivery of care. Writing with sociologist Iain Wilkinson, Kleinman argues that critique in itself does not make an adequate contribution to the issue of social suffering (Wilkinson and Kleinman, 2016: 156); in their book *A Passion for Society* they develop a strong commitment to "a possible reconfiguration of social science as a critical practice of accompanying and caring, protecting and liberating" (ibd., 21). Kleinman has extended his commitment with social science as a field of social care and caring practice to his involvement with Global mental health. Hence, he defines one of the issues for medical anthropology for the next fifty years to examine mental health problems as social suffering in order to "advance global mental health" (Kleinman, 2012: 123). GMH has to make the moral

case for the mentally ill and address the pain and suffering (the moral life) of people living with mental illness (Kleinman, 2009; Patel et al., 2006).

Within their projects of moral anthropology, Kleinman and Fassin's ethnographic approaches have distinct styles. Fassin occupies himself with the circulation and impact of moral economies, involving contextualized historical reconstructions of meso-social (between micro and macro) public policies or interventions of non-governmental origin dialectically interspersed by the recording and analyses of local ramifications and perceptions of these changes in the lives of the individuals involved (Fassin, 2005, 2009, 2012b). Kleinman opts for reconstructing personal narratives, prioritizing the description of how individuals interpret and operate these economies in their lives (Kleinman, 2006).

Notwithstanding these divergences and differences, Didier Fassin and Arthur Kleinman are both committed to moral anthropology approaches, which, albeit different, can advance a moral critique to ontological uses of culture within Global Mental Health literature. We extend to Kleinman some elements Kopper (2014) stresses in describing Fassin's critical moral anthropology. Both approaches are interested in the forms of subjectivation produced by ethics and moralities. However, based on the fact that these forms are constituted by subjects within relations, Kleinman bets on understanding relations as an element found in the exploration of subjectivities, while Fassin moves in the opposite direction, inferring understanding of subjects from relations. In both cases, the adjective "moral" does not represent the defense of a specific system of values and rules, but the interest in studying how subjects and subjectivities are constituted within moral references and through morally valuable practices.

Returning to the GMH arena, we propose that a moral anthropology, in that perspective, can be useful to explore local worlds involved in GMH agenda. That approach may be of meaning relevance in scenarios, like urban Brazilian contexts, where a "silencing of culture" (Ortega e Wenceslau, 2019) soundly grounds our national social representation and also the academic production around the subject. We bring as an illustration our own fieldwork experience with therapeutic approaches to people with depressive symptoms in a primary health care setting in Rio de Janeiro (Wenceslau and Ortega, in press). Our ethnographic research evinces that primary care physicians worked with a categorization of depression between "morro" (hill) and "asfalto" (asphalt) that had important significance and consequences for both, patients and health professionals.

For these health professionals, the depressive conditions presented by the slum dwellers - “morro” - were distinct from those presented by the residents of the richer and most urbanized territories - “asfalto” and even demanded different therapeutic strategies. Depression in the “asfalto” was conceived mainly as a result of social isolation and manifested by more psychological symptoms such as sadness and loss of interest in daily activities. Its therapeutic approach, in addition to medication, involved, especially, the insertion of these people in therapeutic and social groups, with the goal of “creating a network” for them. The depression in the “morro” resulted from an intense subjective disruption, derived from the accumulation of various experiences of violence and frustration. For the doctors who accompany those patients, in the favelas people had more social support and community life than in the asphalt. However, the losses and difficulties of the hill dwellers were so immense that, at a certain moment, they “exploded” in an intense and summing depressive situation which extrapolate the community support. For those individuals, physicians provided more consultations and individual psychosocial interventions aimed at a therapeutic embrace of their narratives of suffering and a “reengagement with life”.

Although we identified evidence of illness patterns associated with that categorization, the study of individual trajectories presented several elements that contradicted a homogeneous replication of these patterns. The “hill” and “asphalt” labels proved to be a source of tensions in the field, especially when the moral stakes of physicians and patients around these categories were evident. “Hill” and “asphalt” worked as moral economies that were reconfigured into different approaches to provide care for the depressive symptoms of that population and have important consequences for the type of treatment and the therapeutic resources offered to those patients.

To further illustrate how a moral “turn” differs from what we criticized as a “cultural” approach, we use the example of our research on depression in the *morro/asfalto* and speculate how those issues would be handled by GMH advocates and critics in relation to their approach to cultural issues. GMH advocates would probably promote the examination of alleged “cultural” aspects of “hill” and “asphalt” depression, while trying to establish a symptom profile (resulting from a biological basis) common to both. GMH critics would collect data that demonstrated the strong social determination of depressive symptoms in these populations and the analysis of health professionals' attitude of medicalizing them or not. Both research directions, while plausible, would not address the moral trajectory of the “hill” and “asphalt” categories in the particular context we studied, in which both patients and professionals seemed more interested in pragmatically adding and merging therapeutic resources than excluding or refusing them for belonging to a particular epistemic or cultural matrix.

It is worth noting that the debates in GMH may be addressed through a moral approach without necessarily choosing one side. The moral perspective that we explored allows to describe this process and critically following the subjective transformations produced by it, focusing both on the social relations that constitute subjectivities and the individuals' subjective experience.

Final remarks

In this article we have analyzed some controversies and debates within Global Mental Health as a case study of the ontological use of culture as a *locus* for social sciences, especially anthropology, in interface with medicine and public health. We propose that large part of GMH advocates and critics' claims grounds on a reified, ontologized understanding of culture. That understanding, although valid as a social theory resource, is frequently naturalized in the arguments of both sides of the debate. As a consequence, social inquiry is reserved a limited and impoverished role of data gathering for or against the GMH agenda and nourishes an unsolvable controversy, as it is rooted in ontological assumptions. As an alternative, we examine relevant aspects of Arthur Kleinman and Didier Fassin's moral anthropological projects that gravitate, respectively, around individuals' moral experience and the impacts of the circulation of moral economies in this process. We propose that this "moral turn" may constitute a way to avoid the polarization of GMH debates. Moreover, it can be a useful theoretical approach for field research in scenarios where culture is "silenced" and therefore does not constitute a valid analytic category. An acritical ontological use of culture rather satisfies the needs of the researchers and their own social interests than helps to understand "what is at stake" for the different actors and the complexity of their worlds.

However, one can not foresee that the shift from "culture" to "moral" will not result once again in the naturalization of theoretical categories and polarization of the debate. There is certainly a risk of just shifting the locus of the problem. We are aware of that. Still, we believe that the "moral turn" may offer two possible advantages for contemporary anthropological research in Global Mental Health. First, as we have already remarked, it is an alternative for ethnographic research in fields where culture is not "at stake", as we believe to be the case in urban scenarios in Brazil. For the same reason, it is also useful when cultures are ontologically considered, although their transformations and interactions are not seen necessarily as a problem, but an unavoidable social process, whose moral and political assumptions and interests must be critically analyzed by the social sciences (Miller, 2014).

Second, and as a kind of antidote to the dangerous naturalization of moral assumptions, especially of researchers, a moral anthropology of GMH invites us to expose our own moral values,

our projects of science and society. To assume a critical position is not to assume a neutral one. We agree with Fassin that critique is inherent to anthropology (Fassin 2017). But critique should not be paralyzing. We don't think that to assume a critical stance necessarily precludes moral and political intervention. Echoing the analytical horizon proposed by Kleinman (2013), we propose an empirical practice of mental health research that is committed to produce results that are in some way useful and beneficial to providing health care to people with mental health difficulties within the public sphere. In particular, we have reservations regarding Fassin's statement that "a moral anthropology has no moralizing project" (Fassin, 2012b: 3). Could anthropology or the social sciences have a "moral" project that is not "moralizing"? We therefore see other possibilities in Wilkinson and Kleinman's (2016: 158) perspective when they state, as an alternative to the less propositional position indicated by Fassin, that "our sensitivity to problems of human suffering, particularly insofar as it involves us in vexed questions of moral meaning and in frustrated debates over the bounds of the moral responsibilities we bear toward others" may be taken as "a means to awaken human social understanding."

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References

Abu-Lughod, Lila. (1991). "Writing against Culture," In Richard G. Fox (ed.) *Recapturing Anthropology: Working in the Present*. Santa Fe: School of American Research Press, pp. 137-154, 161-162.

Adams, V. (2016). "Metrics of the global sovereign: Numbers and stories in global health". In V. Adams (Ed.), *Metrics: What counts in global health* (pp. 21–68). Durham, NC: Duke University Press.

Adams, V. et al. (2019): "Re-imagining global health through social medicine", *Global Public Health*. DOI:10.1080/17441692.2019.1587639

American Psychiatric Association (APA) (2013) *Diagnostic and statistical manual of mental disorders: DSM-5™*. Arlington, VA, US: American Psychiatric Publishing, Inc..

Alexandrakis, O. (2001) "Medical Anthropology: The Development of the Field," Totem: The University of Western Ontario Journal of Anthropology: Vol. 9: Iss. 1, Article 8.

Bass, J.K. et al. (2007). Do not forget culture when studying mental health, *The Lancet*, 370, 9591, 918–919.

Birn, A.-E. (2014). "Philanthrocapitalism, past and present: The Rockefeller Foundation, the Gates Foundation, and the setting(s) of the international/global health agenda". *Hypothesis*, 12, e8. doi:10.5779/hypothesis.v12i1.229

Birn, A.-E., Nervi, L., & Siqueira, E. (2016). "Neoliberalism Redux: The global health policy agenda and the politics of cooptation in Latin America and beyond". *Development and Change*, 47, 734–759. doi:10.1111/dech.12247

Bracken, Patrick, Giller, Jean. and A, Derek. (2016). Primum non nocere. The case for a critical approach to global mental health. *Epidemiology and Psychiatric Sciences* 25 (6): 506-510.

Callard, F. & Fitzgerald, D. (2015). *Rethinking Interdisciplinarity across the Social Sciences and Neurosciences*. Palgrave Macmillan.

Clifford, James. (1988). *The Predicament of Culture. Twentieth-Century Ethnography, Literature, and Art*. Cambridge, MA: Harvard University Press.

Cohen, A. et al. (2014) A brief history of global mental health. In: Patel V, Minas H, Cohen A, Prince M, organizadores. Global Mental Health: principles and practice. New York: Oxford University Press; p. 3-26.

Collier, S. J., and Ong, A. (2005). Global assemblages, anthropological problems. In S. Collier, & A. Ong (Eds.), *Global assemblages: Technology, politics, and ethics as anthropological problems* (pp. 3–21). Malden, MA: Wiley-Blackwell.

Cooper, S. (2016). Global mental health and its critics: Moving beyond the impasse, *Critical Public Health*, 26, 4, 355–358.

Cox, Nigel and Webb, Lucy. (2015). Poles apart: does the export of mental health expertise from the Global North to the Global South represent a neutral relocation of knowledge and practice? *Sociology of Health and Illness*, 37 (5): 683-697.

Davar, B. V. (2014). Globalizing psychiatry and the case of 'vanishing' alternatives in a neo-colonial state. *Disability and the Global South*, v. 1, n. 2, p. 266-284, 2014.

Dianteill, Erwan. (2012). Anthropologie culturelle ou anthropologie sociale? Une dispute Transatlantique. *L'Année sociologique* 62: 93-122.

Downey, G., and Lende, D. (2012). Neuroanthropology and the Encultured Brain. In D. Lende and G. Downey (eds.). *The Encultured Brain: An Introduction to Neuroanthropology*. Cambridge, MA: MIT Press. 23–66.

Eagleton, Terry. (2000). *The Idea of Culture*. Malden, MA: Blackwell Publishers.

Ecks S. (2016). The strange absence of things in the "culture" of the DSM-V. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne*, 188(2), 142–143.

Fassin, D. [No date]. Towards a critical moral anthropology: an European Research Council Programme. La Lettre, 49. Échos de la recherche. La Lettre de l´EHESS. Available at: http://lettre.ehess.fr/3323 [Accessed: 3rd June 2017].

Fassin, D. 2001. Culturalism as Ideology. In: Carla Obermeyer (ed). *Cultural Perspectives on Reproductive Health*. Oxford: Oxford University Press, 300-317.

Fassin, D. (2004a). Public health as culture. The social construction of the childhood lead poisoning epidemic in France. *British Medical Bulletin*, 69: 167–177.

Fassin, D. (2004b). E la souffrance devint sociale. De l'anthropologie médicale à une anthropologie des afflictions. *Critique*, 680-681: 16-29,

Fassin, D. (2005). Le sens de la santé. Anthropologie des politiques de la vie. In: Saillant, F., Genest, S. (eds) *Anthropologie médicale. Ancrages locaux, défis globaux*. Québec: Les Presses de l'Université Laval; Paris: Anthropos, pp. 383-399.

Fassin, D. (2006). Souffrir par le social, gouverner par l'écoute: une configuration. *Politix*, 73: 137-157.

Fassin, D. (2009). Another politics of life is possible. *Theory, Culture & Society*, 26, 5, 44-60.

Fassin, D. (2012a). That Obscure Object of Global Health. In: Inhorn, Marcia C., Wentzell, Emily A. Medical Anthropology at the Intersections: Histories, Activisms, and Futures. Durham and London: Duke University Press.

Fassin, D. (2012b). Introduction: Toward a Critical Moral Anthropology. In: FASSIN, D. (ed) A companion to moral anthropology. Malden: Wiley Blackwell, pp. 1-18, 2012.

Fassin, D. (2012c). Humanitarian *Reason: A Moral History of the Present*. Berkeley: University of California Press.

Fassin, D. (2015). Santé globale, un nouveau concept? Quelques enseignements de l'épidémie à virus Ebola. Medicine/Sciences (Paris) 31: 463–464.

Fassin, D. (2017). "The endurance of critique", *Anthropological Theory*, 17(1): 4-29.

Fassin, D., & Rechtman, R. (2005). An Anthropological Hybrid: The Pragmatic Arrangement of Universalism and Culturalism in French Mental Health. *Transcultural Psychiatry*, *42*(3), 347–366.

Fernando, S. (2014). Globalization of psychiatry - a barrier to mental health development, *International Review of Psychiatry*, 26, 5, 551-557.

Gupta, Akhil, and James Ferguson. (1992). "Beyond 'Culture': Space, Identity, and the Politics of Difference." *Cultural Anthropology* 7: 6–23.

Gureje, Oye and Stein, Dan J. (2014). Disorders, Diagnosis, and Classification. In: Patel, Vikram; Minas, Harry, Cohen, Alex and Prince, Martin. *Global mental health*: principles and practice. New York, NY: Oxford University Press.

Haroz, E.E. et al. (2016). Depression symptoms across cultures: an IRT analysis of standard depression symptoms using data from eight countries, *Social Psychiatry and Psychiatric Epidemiology*, 51, 7, 981-91.

Heywood, Paolo. (2017). Ontological Turn, The. In: Stein, Felix, Lazar, Sian, Candea, Matei, et al.

(eds) *The Cambridge Encyclopedia of Anthropology*. http://doi.org/10.29164/17ontology.

Ingold, Tim. (ed.) (1996). *Key Debates in Anthropology*. London/New York: Routledge.

Insel, Thomas et al. (2010). Research domain criteria (RDoC): Toward a new classification framework for research on mental disorders. *The American Journal of Psychiatry 167*(7): 748-751.

Jacob, K. S. et al. Mental health systems in countries: where are we now? *The Lancet* 370(9592): 1061-77.

Jenkins, Janis H. (2007). Anthropology and psychiatry: the contemporary convergence. In: Bhugra, Dinesh and Bhui, Kameldeep (eds*) Textbook of cultural psychiatry*. London: Cambridge University Press.

Kelly, A., & McGoey, L. (2018). "Facts, power and global evidence: A new empire of truth". *Economy and Society* Special Issue of Economy and Society, 47(1), 1–26. doi:10.1080/03085147.2018.1457261.

Kirmayer, L.J. (2006). Beyond the 'new cross-cultural psychiatry': cultural biology, discursive psychology and the ironies of globalization, *Transcultural Psychiatry*, 43, 1, 126-44.

Kirmayer, L.J. (2007). Cultural psychiatry in historical perspective. In Bhugra, D. and Bhui, K. (eds) *Textbook of Cultural Psychiatry*. Cambridge, UK: Cambridge University Press, pp. 3-19.

Kirmayer, L.J. and Pedersen, D. (2014) Toward a new architecture of global mental health. *Transcultural Psychiatry*, 51, 6, 759-776.

Kleinman, Arthur M. (1977). Depression, somatization and the 'new cross-cultural psychiatry'. Social Science and Medicine, 11, 3–10.

Kleinman, Arthur M. (1986). Social origins of distress and disease: Depression, neurasthenia, and pain in modern China. New Haven, CT: Yale University Press.

Kleinman, Arthur M. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. British Journal of Psychiatry, 151, 447–454.

Kleinman A. (2006). *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oxford University Press

Kleinman, A. (2009). Global mental health: a failure of humanity, *The Lancet*, 374, 9690, 603-604.

Kleinman, A. (2012). “Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years.” In Marcia C. Inhorn and Emily A. Wentzell, (eds). *Medical Anthropology at the Intersections: Histories, Activisms, and Futures*. pp. 116-128. Durham, NC: Duke University Press.

Kleinman, A. (2013). From illness as culture to caregiving as moral experience, *New England. Journal of Medicine*, 368, 15, 1376-7.

Kleinman, A. and Benson, P. (2006) Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It, *PLoS Medicine*, 3, 10, e294.

Kleinman, A., Eisenberg, L. and Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research, *Annals of Internal Medicine*, 88, 2, 251-8.

Kleinman, A. and Kleinman, J. (1991). Suffering and its professional transformation: toward an ethnography of interpersonal experience, *Culture, Medicine and Psychiatry*, 15, 3, 275-301.

Kleinman, A. and Fitz-Henry, E. (2007). The experiential basis of subjectivity: how individuals change in the context of societal transformation. In: Biehl, J., Good, B. and Kleinman, A. (eds) *Subjectivity: ethnographic investigations.* Berkeley, CA: University of California Press. pp. 52-65.

Kohrt, Brandon A. et al. (2014) Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology* 43(2):365-406.

Kohrt, Brandon A. and Mendenhall, Emily (eds). (2015). Global Mental Health: anthropological perspectives. Walnut Creek, CA: Left Coast Press.

Kohrt, Brandon A. et al. (2016). How anthropological theory and methods can advance global mental health, *Lancet Psychiatry*, 3, 5, 396-8.

Kopper, M. (2014). Nos limites da intervenção: a antropologia crítica de Didier Fassin, *Mana*, 20, 2, 355-370.

Kroeber, Alfred L. and Clyde K. Kluckhohn. (1952). *Culture: A Critical Review of Concepts and Definitions*. New York: Random House.

Kuper, A. (1999). Culture: The Anthropologists' Account. Cambridge, MA: Harvard University Press.

Lancet Global Mental Health Group (2007) Scale up services for mental disorders: A call for action. *The Lancet* 2007; 370: 1241-52.

McGoey, L. (2015). *No such thing as a free gift: The gates foundation and the price of philanthropy*. London: Verso.

Meloni, Maurizio. (2016). *Political Biology: Science and Social Values in Human Heredity from Eugenics to Epigenetics*. Palgrave.

Meloni, M., Williams, S. and Martin P. (eds). (2016). *Biosocial Matters: Rethinking Sociology-Biology Relations in the Twenty-First Century*, Oxford: Wiley-Blackwell.

Miller, Gavin. (2014). Is the agenda for global mental health a form of cultural imperialism? *Medical Humanities*, 40, 2, 131-4.

Mills, China and Fernando, Suman. (2014). Globalising Mental Health or Pathologising the Global South? Mapping the Ethics, Theory and Practice of Global Mental Health, *Disability and the Global South*, 1 (2): 188-202.

Mills, C. and White, R.G. (2017). 'Global Mental Health Spreads Like Bush Fire in the Global South': Efforts to Scale Up Mental Health Services in Low- and Middle-Income Countries. In White, R.G. et al. (eds) The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health. London: Palgrave Macmillan, pp. 187-209.

Murphy, M. (2017). *The economization of life*. Durham and London: Duke University Press.

Nestler, Eric J. et al. (2002). Neurobiology of Depression. *Neuron* 34(1):13-25.

Ortega, Francisco and Vidal, Fernando. Eds. (2011). Neurocultures. Glimpses into an expanding universe. Frankfurt and New York: Peter Lang.

Ortega, Francisco and Wenceslau, Leandro David. (2019). "Challenges for implementing a global mental health agenda in Brazil: The 'silencing' of culture." *Transcultural Psychiatry*. 0(0) 1–23. doi.org/10.1177/1363461518824433

Patel, V. (2012). Global mental health: From science to action. Harvard Review of Psychiatry, 20(1), 6–12.

Patel, Vikram. (2013). Is global mental health the 'Americanization of mental illness'? *ThInk Neuroscience*, 07 jan. 2013. Available on: <https://thinkneuroscience.wordpress.com/2013/01/07/global-mental-health/>. Acesso em: 15 mai. 2017.

Patel, Vikram (2014). Why mental health matters to global health. *Transcultural Psychiatry* 51(6): 777-89.

Patel, V., Saraceno, B. and Kleinman, A. (2006). Beyond evidence: the moral case for International Mental Health. *American Journal of Psychiatry*, 163, 8, 1312-1315.

Patel, V. et al. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*. 2007; 370(9591):991-1005.

Prince, M. et al. (2007). No health without mental health. *The Lancet* 370(9590):859-77.

Read, John et al. (2016). In search of an evidence-based role for psychiatry. *Future science OA* 2(1): FSO101.

Reed, Geoffrey M. et al. (2019). Innovations and changes in the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. *World Psychiatry* 18(1): 3-19.

Rose, Nikolas. (2013). The Human Sciences in a Biologcal Age. *Theory, Culture & Society*, 30(1), 3–34.

Sahlins, Marshall. (2000). “Sentimental Pessimism and Ethnographic Experience; or Why Culture is not a Disappearing Object.” In *Biographies of Scientific Objects*, ed. Lorraine Daston, 158–202. Chicago: University of Chicago Press.

Scheper-Hugues, Nancy. (1984). “The Margaret Mead Controversy: Culture, Biology and Anthropological Inquiry.” *Human Organization* 43 (1): 85–93.

Shweder, Richard A. (1991). “Thinking through Culture”. In *Expeditions in Cultural Psychology*. Cambridge, MA: Harvard University Press.

Schweder R (2003). *Why do Men Barbecue? Recipes for Cultural Psychology*. Harvard University Press: Massachussetts.

Snodgrass, J. G. et al. (2017). Religious Ritual Is Good Medicine for Indigenous Indian Conservation Refugees: Implications for Global Mental Health, *Current Anthropology*, v. 58, n. 2, p. 257-284, 2017.

Sobo, E. J. (2016). “What is herd immunity, and how does it relate to pediatric uptake? US parent perspectives.” *Social Science & Medicine*, 165, 187–195. doi:10.1016/j.socscimed.2016.06.015.

Sood, A. (2016). The Global Mental Health movement and its impact on traditional healing in India: A case study of the Balaji temple in Rajasthan, *Transcultural Psychiatry*, 53, 6, 766–782.

Stellmach, Darryl et al. (2018) Anthropology in public health emergencies: what is anthropology good for? *BMJ Global Health* 3:e000534.

Stein, Dan J. et al. (2013). Classification Systems in Psychiatry: Diagnosis and Global Mental Health in the Era of DSM-5 and ICD-11. *Current Opinion in Psychiatry* 26(5): 493–497.

Storeng, K. T. and Béhague, D. (2017). "“Guilty until proven innocent”: the contested use of maternal mortality indicators in global health”, *Critical Public Health*, 27:2, 163-176, DOI: 10.1080/09581596.2016.1259459

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health. *British Medical Journal*, 336, 992–994.

Summerfield, D. (2012). Afterword: against "global mental health", *Transcultural Psychiatry*, 49, 3-4, 519-30.

Tylor, Edward. (1871). *Primitive Culture. Researches into the Development of Mythology, Philosophy, Religion, Art, and Custom*. London: John Murray.

Vidal, Fernando & Ortega, Francisco. (2017). *Being Brains: Making the Cerebral Subject*. New York: Fordham University Press.

Vidal, Fernando & Ortega, Francisco. (2018). "On the Neurodisciplines of Culture." In: Maurizio Meloni; John Cromby; Des Fitzgerald; Stephanie Lloyd. Eds. *Palgrave Handbook of Biology & Society*. London: Palgrave MacMillan, p. 371-390.

Wenceslau, Leandro David and Ortega, Francisco. (In Press). "Urban Mental Health and the Moral Economies of Suffering in a 'Broken City': Reinventing Depression among Rio de Janeiro Urban Dwellers". In: Michael Keith and Andreza de Souza Santos. Eds. *Urban Transformation and Public Health in emergent Cities of the Future*. Manchester: Manchester University Press.

White, Ross. (2013). The globalisation of mental illness. *The Psychologist*, 26(3): 182-185.

White, Ross G. and Sashidharan, Sashi P. (2014) Towards a more nuanced global mental health, *British Journal of Psychiatry*, 204 (6): 415-417.

Wilkinson, I. and Kleinman, A. (2016). *A passion for society: how we think about human suffering.* Oakland: University of California Press.

Williams, Raymond. (1985). *Keywords: A Vocabulary of Culture and Society*. Rev. ed. London: Fontana.

Wyatt, W. Joseph and Midkiff, Donna M. (2006). Biological psychiatry: a practice in search of a science, *Behavior and Social Issues*, 15 (2): 132-151.