WHERE THERE ARE (NO) DRUGS: THE MOVEMENT FOR GLOBAL MENTAL HEALTH AND THE USE OF PSYCHOPHARMACEUTICALS IN EAST AFRICA

Bryan Mark Dougan

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Approved by:

Peter Redfield

Jocelyn Chua

Lydia Boyd

ABSTRACT

Bryan Mark Dougan: Where there are (No) Drugs: The Movement for Global Mental Health and the Use of Psychopharmaceuticals in East Africa
(Under the direction of Peter Redfield)

This research traces new discourses and practices related to pharmaceuticalization in global health research interventions for depression. In the era of "biomedical psychiatry" and "global health," life-saving pharmaceuticals have become an increasingly dominant mode of treating patients. Around the world, especially in the Global South, groups have fought with governments and corporations to secure access to these drugs despite global patent laws and the desire to generate significant profits. For a small group of research who are part of the Movement for Global Mental Health, however, their discourses and interventions reject the use of medications from global pharmaceutical companies in treating depression while infrequently using medications produced in local markets. This paper seeks to think through anthropological concerns of pharmaceuticalization when medications are not present or a priority by examining underlying logics of how these researchers do and do not use pharmaceuticals.

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CHAPTER 1: "Global Mental Health is not Big Pharma."

In this paper I discuss the place of pharmaceuticals within the Movement for Global Mental Health (GMH), with a case study on how they implement depression treatments in East Africa. In most circumstances globally, especially in East Africa, GMH researchers implement research-interventions to examine the reduction of depressive symptoms using talk therapies, or psychosocial interventions, instead of pharmaceuticals. In a recent April 2016 keynote address at Georgetown University, Vikram Patel, an Indian psychiatrist who is one of the chief architects of GMH, emphatically reiterated that they avoid pharmaceuticals as much as possible in order to separate themselves from the influence of pharmaceutical companies in other medical spheres: "Global Mental Health is not Big Pharma." Later at the conference where Patel spoke, someone asked a question about pharmaceuticals during a Q&A session after a panel. The panelist responded briefly, noting that if pharmaceuticals are used, they should be used contextually. If we consider the context of the first three studies that would facilitate GMH's emergence, researchers associated with GMH have not conducted pharmacological interventions to treat depression in Uganda (Bolton et al, 2003). In contrast, GMH interventions in India (Patel et al, 2003, 2010) and Chile (Araya et al, 2003) have had pharmaceutical components for depression trials.

Prior to helping launch the Movement for Global Mental Health, in 2003 Patel published a book entitled *Where There is No Psychiatrist: A Mental Health Care Guide*. This book serves as a guide for non-physician, mental health practitioners in the absence of a trained psychiatrist,

particularly in the Global South. It lays out strategies on how to diagnose and treat patients, which includes pharmaceuticals. Thirteen years after the publication that text and one of his first studies in India, Patel's publications and speech suggest a change of mind. Such change of mind is reflected in the title of this essay. Patel's book title definitively proscribes methods to approach mental health in the absence of trained doctors. The parenthesis in the title of this essay, however, reflect uncertain place of pharmaceuticals in GMH. Here, I argue that pharmaceuticals have a subordinated place in the Movement for Global Mental health rhetoric and research publications. It is not a question of whether they are present; they are. Instead, this essay seeks to understand where exactly pharmaceuticals are and the logics behind their use.

In discussing the place of pharmaceuticals within the Movement for Global Mental Health (GMH), I use a case study on depression treatments in East Africa because of GMH's heavy emphasis on treating mood disorders in contrast to other mental health disorders. If GMH is not a front for pharmaceutical companies, according to Patel's claim, yet there are pharmaceutical studies that claim linkages to GMH, where are pharmaceuticals in the broader political economy of GMH, psychiatric practices, and corporate influences? How can we think about this non-use – or dare I say, later rejection – of pharmaceuticals in an era where some anthropologists claim the world is becoming more pharmaceuticalized (Biehl, 2007; Jenkins, 2010)? Vikram Patel (2003) has considered the kind of practices needed "where there is no psychiatrist." This paper is part of what can become a broader discussion of what happens in global psychiatric practices "where there are (no) pharmaceuticals."

The example of GMH's (non) use of pharmaceuticals, especially in East Africa, requires further investigation because it does not follow the expected trajectory of anthropological research concerning global health and psychiatry. Following anthropologist João Biehl (2007),

we would expect GMH would have a more "pharmaceutical-centered public health" vision for health and treatment. Yet Patel and others reject and sparingly use pharmaceuticals in their interventions. Psychiatry as well, according to anthropologist T.M. Luhrmann (2000), has undergone a shift from more psychotherapy treatments to pharmacological regimens. GMH, however, implements more talk therapy programs than pharmaceutical programs. While in many places of the world pharmaceuticals are the dominant therapeutic regimes, GMH's rhetoric and practices run against the grain of both Biehl and Luhrmann's theorizations.

I situate this work within the broader conversations around "Critical Global Health" (Biehl & Petryna, 2013; Adams, 2016). Here, I am not interested in taking a stance on the practices of GMH researchers; there is enough internal GMH debate on their own practices and assumptions (Patel, 2014; Summerfield 2008, 2012). Instead, this paper examines the practices and underlying assumptions and contradictions of a particular group of scientists and their work, which ultimately seeks to alleviate very real suffering and anguish in the world. In drawing on my experience at the April 2016 conference and the GMH scientific literature, I think of this work as an "ethnography of a subfield."[1] Following anthropologist Alex Nading's (2015) work on dengue scientists, I explore the actions and discourses of a particular group of scientists as their try to achieve their goals. GMH scientists, in contrast to the dengue scientists that Nading followed, actively do not appeal to pharmaceutical companies for funding and therapies.

As such, I aim to make two related arguments: First, I suggest that scientists who claim their work as "global health" do not all have the same political-economic relationship to pharmaceutical corporations and deploy market logics differently based on the politics and histories of the particular disease on which their work focuses. Second, that the work of GMH

[1] Thanks to Luise White for this turn of phrase as a point of clarification in her discussant comments at the Triangle African Studies Workshop.

scientists asks anthropologists to reconsider the role of pharmaceuticals in global health interventions. While it is certainly true that many environments are increasingly pharmaceuticalized, I hope to demonstrate that GMH spaces are actively and intentionally not therapeutically pharmaceutical spaces.

I begin this discussion with the place of pharmaceuticals in the GMH literature. Then, I discuss GMH's relationships to global health and psychiatry. With this in mind, I review recent anthropological literature around pharmaceuticals in relationship to GMH. As a case study, I discuss the Bolton study mentioned previously to consider the role of pharmaceuticals in GMH in East Africa. I will use three initial studies published in 2003 that are, arguably, the first three Global Mental Health research-interventions (Patel et al, 2003): the Araya et al (2003) study in Chile, the Bolton et al (2003) study in Uganda, and the Patel et al (2003) study in India. In the context of the Bolton study, is there something about the East African context where Bolton and his colleagues begin their work that creates space for non-pharmaceuticalized practices?

CHAPTER 2: Pharmaceuticals as Non-Priority

I begin with an examination of how pharmaceuticals broadly, not just medications for depression, are discussed in agenda-setting documents that GMH researchers have themselves published in peer-reviewed journals and textbooks and WHO policy documents on which they draw (For more extensive review on GMH, see Bemme & D'Souza, 2014). At stake is the ways in which GMH supports (or does not) the use of pharmacological interventions in low-resource settings. In doing this, I examine the discursive practices in which GMH actors engage around pharmaceuticals as researchers set their goals. I argue that from the outset of GMH, unlike elsewhere in global health, it appears that pharmaceuticals are not a priority in developing interventions or building health system infrastructure in low-resource settings. I will suggest several factors for this, including adherence to a logic of "cost-effectiveness" and the relationship between ethics and infrastructure.

In 2007, the *Lancet* published six articles as part of a series on "Global Mental Health" (GMH). Authored by researchers trained in anthropology, epidemiology and medicine (especially psychiatry), among others, these articles followed conventional global health topics: current knowledge on the global burden of psychiatric disorder and the relationship of psychiatric illness to other global health challenges such as HIV/AIDS, access to treatment and prevention, several on health services and infrastructure, and the final call to action. GMH has two main goals: decrease prevalence of mental disorder (Kessler et al, 2005) and close the treatment gap, defined as the difference between the number of people with a mental disorder

and their ability to get services, the implications on the work of GMH actors I will address throughout the text (Patel et al, 2010). While GMH discusses mental illnesses broadly, researchers tend to focus on mood disorders, like depression and Post-Traumatic Stress Disorder (PTSD), instead of psychotic disorders like schizophrenia (Patel & Kleinman, 2003; Lund et al, 2012).

In the 2007 *Lancet* publications, scholars briefly discuss pharmaceuticals for depression. In their review of treatment and prevention, Patel et al (2007) provide the context of five randomized control trials that reduced depression in low- and middle-income countries. Of these five, only the Ayara and Patel studies, involved pharmaceuticals. In the sixth essay, pharmaceuticals are part of the action plan. In listing among the primary targets making "basic pharmacological treatments available in primary care" (Lancet Global Mental Health Group, 2007: 1244), the authors call for increased treatment access, a central tenet of global health-related projects (Biehl & Petryna, 2013). The authors define the measure as increased pharmaceuticals for a number of psychiatric disorders, not just depression.

While researchers used pharmaceuticals in important studies leading up to the first GMH publications, they are rarely found even in more recent studies. For example, in 2014 GMH researchers started their own journal, *Global Mental Health*. An open access journal published yearly, its formation further solidifies GMH as a sub-discipline within global health. By creating specific means through which to offer researchers an outlet to publish, GMH scholars indicate they have established enough evidence to warrant their own journal. In a review of titles and searching the first three editions of journal, not a single publication focuses on the provision or use of pharmaceuticals in a research environment. Publications instead focus on epidemiological studies and outcomes of research interventions around the world on a broad range of mental

disorders and comorbidities, as well as offering a space for editorial debates. Focusing on non-pharmaceutical interventions and studies suggests that the emphasis for treatment is lies beyond the pharmaceutical-based models for public health work.

In 2011, important publications emerged in two journals. First, in July 2011, led by Pamela Collins at the US' National Institutes of Mental Health, researchers published the "Grand Challenges for Global Mental Health," listing out twenty-five priorities for the GMH movement to guide research in *Nature*. In this list, Collins and her colleagues (2011:29) state that one of their top five priorities is to "Reduce the cost and improve the supply of effective medications." The other four broadly look towards the goal of health system capacity building, or in global health parlance, "scaling up." And yet, Collins and her coauthors also offer a move towards removing pharmaceuticals. In a list of research questions, Collins et al (2011: 29) write, "How will increased understanding of neural circuits lead to alternatives to current pharmacological interventions?" I interpret this question as looking forward to the future when researchers can design interventions informed by how the brain works without needing medications. Following this logic, then, neuroscience becomes the site of developing alternative interventions to pharmaceuticals. This, of course, is interesting given the lack of focus on, if not rejection of, using neuroscientific models in GMH, which I discuss in detail later. It is unclear what exactly these alternatives would be and how they would operate in low-resource settings. Nevertheless, this focus on the brain without medication suggestions a horizon of imagination that envisions the separation of science, here neuroscience neurobiology, from its political economic influence, i.e. big pharma, and can help people undefiled by corporate priorities.

The second important set publications are published in October-November in the *Lancet* as the second series on Global Mental Health, a follow-up and expansion on the initial 2007

series. In these papers, psychopharmaceuticals are mentioned as a concern but not identified as a priority. In the first paper, Lund et al (2011) state that psychotropic drugs can play a role in reducing poverty through the reduction of mental illness, yet it is not listed as a priority. The same is true of the assessment of humanitarian settings by Tol et al (2011): drugs have been used, but they are not a solution. In their discussion of scaling up mental health services, Eaton et al (2011) note that low- and middle-income countries need drugs but have neither the infrastructure nor the data to make psychopharmaceuticals a focus of care. In this way, like the first *Lancet* series, psychotropic drugs, regardless of diagnosis, are not included in recommendations.

Agenda-setting journal publications are not the sources of GMH policy and ideas. Of importance to GMH are also World Health Organization (WHO) initiatives. In 2001, the WHO published its annual *World Health Report* focused on mental health entitled *Mental Health: New Understanding, New Hope*. In this document, the WHO outlines the state of mental health care around the world and various treatment options, including pharmaceuticals. The authors write, "The appropriate treatment of mental disorders implies the rational use of pharmacological, psychological and psychosocial interventions in a clinically meaningful, balanced, and well-integrated way" (WHO, 2001: 55). They reiterate a similar point a few pages later: "The management of mental and behavioral disorders – perhaps more particularly than that of other medical conditions – calls for the balanced combination of three fundamental ingredients: medication (or pharmacotherapy); psychotherapy; and psychosocial rehabilitation" (WHO, 2001: 59). In pairing these three therapeutic activities together, the WHO sets up a three-part model for treatment with which neither GMH researchers or psychiatrists would disagree. The challenge, of

course, is the actualization of this vision for treatment, a challenge the WHO document openly acknowledges.

The WHO authors also acknowledge a point that later seems foundational for GMH interventions and actions: "Encouraging evidence has recently emerged in relation to the cost-effectiveness of psychotherapeutic approaches to the management of psychosis and a range of mood and stress-related disorders, in combination with or as an alternative to pharmacotherapy" (WHO, 2001: 62). One point that is key here is that while this WHO document has a more global vision, its publication happened before GMH scholars began to emerge in a particular formation, at least visibly. The Araya, Bolton, and Patel studies were either underway by this time or finished, although their studies were not published nor they would not put their interventions in conversation with each other until later (Patel et al, 2003b). What this indicates is the WHO put forward a vision related to increased access to and presence of pharmaceuticals, which is tied into its push for essential medicines (Greene, 2011). The GMH scholars do follow its lead, and it is an approach with which they are sympathetic.

A year after the *World Health Report*, the WHO endorsed Mental Health Global Action Program, or mhGAP, which the organization would publish in 2008 (WHO, 2008). The goal of mhGAP is "the WHO action programme developed for countries especially with low and lower middle incomes for scaling up services for mental, neurological, and substance use disorders" (WHO, 2008: 1). The program and its intervention guide, published in 2010 (WHO, 2010), do emphasize pharmacological interventions but alongside of psychosocial interventions like talk therapies. In fact, the mhGAP Intervention Guide provides suggestions on pharmacological research interventions, while directing readers to a 2009 WHO publication called *Pharmacological Treatment of Mental Disorders in Primary Health Care* that lays out in great

detail the kinds of pharmaceutical interventions appropriate for individual disorders. The mhGAP program, according to anthropologist Byron Good (2010: 122), "suggests too few drugs rather than too many, particularly for psychotic illnesses; too little understanding of the potential benefits of medications rather than too great expectations; too little access to the full range of antipsychotics," among other things. The WHO program, then, places significant emphasis on the need to increase access to and knowledge about pharmaceuticals.

So what do we make of their discourses? Even as Vikram Patel acknowledges the mhGAP program in his keynote address, there are clearly different goals between the WHO and GMH documents: the WHO documents want more pharmaceuticals whereas GMH does not. In the Grand Challenges and the original call to action, GMH researchers put forward as a therapy worth investing in. This aspiration, however, is contextual: "Even new and highly effective pharmacological treatments would need well functioning health systems to deliver them, and psychosocial interventions to accompany them, if they were to be effective" (Lancet Global Mental Health Group, 2007: 1246-7). In this sense, the GMH documents overlap with the WHO guides, indicating pharmaceuticals require functioning health care systems, but, the tone this quote offers some hesitation. Yet each group draws slightly different lessons from needing a functioning health system. GMH operates in a "projectified landscape" (Whyte et al, 2012) where GMH researchers develop small-scale projects without the promise of long-term systemic care, whereas WHO is typically more focused on government-level programming. With regards to Big Pharma, there is no indication that the WHO rejects Big Pharma in the way that Vikram Patel and his colleagues do, even though some of Patel's coauthors that work for the WHO. For both groups, however, their solution for pharmaceuticals is the provision of government funding

for public health infrastructure that can support acquiring and dispensing of medications as well as support other interventions. Before investing in pharmaceuticals, infrastructure must exist.

CHAPTER 3: Pharmaceuticals and Cost-Effectiveness in GMH

If the GMH policy documents are, at best, ambivalent towards pharmaceuticals, we need to consider some of the reasons why that might be. First, we need to look towards the ideas that bring together a diverse set of actors and ideologies under "global health." This is, in part, because Vikram Patel, in his keynote address in April 2016, sees GMH as "global health, *not* psychiatry." Because of the diversity of actors in global health, it is loosely held together by several principles, one of which is cost-effectiveness (Adams, 2013; 2016). To test and measure cost-effectiveness, global health actors deploy metrics in order to examine if they achieve their goal. In this section, I examine the relationship between ideas of cost-effectiveness, metrics, and the (non) use of pharmaceuticals in Global Mental Health. In examining this relationship, I argue that cost-effectiveness determines the priorities of GMH treats. In using a rubric of cost-effectiveness to determine priorities, GMH actors also determine to not use pharmaceuticals unless contextualized, as the panelist from the 2016 conference remarked.

Cost-effectiveness is defined as "economic calculi [that] are affixed to interventions in what that make cost something that must be accounted for in the same ways that things like 'rates of diarrhea' are counted (and studied statistically). This makes sense because one wants to show that spending money on health care (however much or however little) 'pays off' in health dividends in the end" (Adams, 2013: 70). Researchers must develop measurements to make sure that the way in which they implement an intervention is done well but cheaply; if either are not met, then the study runs the risk of not being published or being published in a less prestigious

journal. In GMH research this means seeing whether or not the reduction of depression or PTSD is commensurate with not only the amount of money spent on the intervention, but also the amount of money it would cost to scale up a program a point to which I return momentarily.

With a goal of scaling up, researchers must also insure that the results of their study will have a wider impact. There are numerous metrics significant to this work, one of which, on a very broad and global scale, is the DALY, or Disability Adjusted Life Year (Murray, 1994; World Bank, 1993; for GMH related critiques of DALY, see Becker et al, 2013; Kleinman & Kleinman, 1994). Developed by economist-physician Christopher Murray and epidemiologist Alan Lopez, "[i]n essence, the DALY provides an economic measure of human productive values by calculating the loss of productivity to disease or disability" (Adams, 2016: 27). Through measuring how much productivity was lost, researchers and policy makers can use the DALY to set policy priorities through allocating funding and resources to combat diseases that took away from economic productivity and growth. The DALY ranks illnesses and countries and facilitates comparison across those categories to determine priorities. The metric does not determine an intervention is, but help researchers and policy makers determine priorities on what illness to focus and for which to develop programs. In considering mental disorders, according to the most recent DALY estimates published in October 2016, depressive disorders rank 15th on the top 30 list of disorders with the highest DALY rates, moving up from 19th in 1990 and 17th in 2005 and anxiety disorders are 28th (GBD 2015 DALYs and HALE Collaborators, 2016: 1633). What this means is that, of the mental disorders, depression has the highest economic burden worldwide since the initial study. To focus on depression means that GMH scholars can have the largest impact on disease worldwide.

This, in part, helps to reveal why depression and depressive disorders are the primary focus of GMH interventions. But what does this have to do with pharmaceuticals? At least two things. First, because depression is highest ranked, other illnesses that require pharmaceuticals, such as bipolar disorder and schizophrenia, are not priorities because to treat them means fewer people will receive treatment. [I will insert prevalence rates here to demonstrate this in final]. To be clear, this is not about the cost of the medications for these disorders, but about how it affects the world population and its economy.

Second, there are several treatment options for depression beyond pharmaceuticals. As such, researchers must decide how to develop interventions for depressive disorders. Will they use medications? Psychosocial interventions? A combination of both? Do they start with human and physical infrastructure first? This decision is also one of cost-effectiveness, especially when researchers use the Randomized Control Trial, or RCT, "the statistically robust, randomized and controlled, cost-effectively constituted, experimentally designed, outcome-measureable intervention/research project (or some proximate version thereof)" (Adams, 2106: 31). Creating at least two groups – an intervention and control group – within a target population, researchers recruit and offer a randomly selected group of eligible participants the possibility to participate. Through using statistical methods and programs, researchers randomly assign each participant to the intervention or the control group. At the end of the trial, researchers compare the groups against each other to see whether the intervention had an impact on particular outcomes.

RCTs can show which treatments are the most cost-effective by comparing them within the same study, always with a control. Considering the three studies from 2003, all of which used the RCT method. In the Bolton and Araya studies, the group therapy interventions were successful in relationship to the control; in the Patel study, the individual therapy was not, which

the authors note was because it was not culturally appropriate (Patel et al, 2003b: 539). In the Araya and Patel studies, using pharmaceuticals proved successful (Patel et al, 2003b: 540). Additionally, "[t]he Indian study showed that treating depression produces a significant reduction in total healthcare costs" (Patel et al, 2003b: 540), something that could not have been seen without the RCT method.

As Patel, Araya, and Bolton (2003: 540) note, "we found evidence for efficacy of depression interventions that we believe are locally feasible and cost-effective among the poorest people in that setting." In other words, the researchers had scalability in mind. In considering feasibility and affordability, Araya, Bolton, and Patel had questions in mind of whether this was something reproducible at a larger level. If the poorest people in a particular setting could afford the treatment on their own, then these interventions could potentially be implemented in other parts of the country and even integrated into national healthcare systems.

Yet feasibility is also cognizant of context. As Bolton and his coauthors (2003: 3117) write, "Both antidepressants and psychotherapy have been shown to be efficacious in numerous controlled trials in developed countries…However, use of antidepressants is not feasible in this region because of high cost and limited supply infrastructure." The lack of pharmaceuticals is because of money and infrastructure. From this, it seems evident that the researchers on the Bolton study wanted to use pharmaceuticals, but ultimately could not justify it because of affordability.

Here the logic of cost-effectiveness overrode the logic of a pharmaceutical-centered public health in Uganda. It was cheaper to translate materials into Luganda, the Ugandan language with the largest number of speakers, to hire and train community health workers, and to implement a talk therapy intervention than it was to treat people with pharmaceuticals. I

hypothesize this choice had to do with a combination of physical infrastructure, especially since there was no clinical component, and the absence of a strong pharmaceutical market. Had the Bolton study happened after 2004 with the Ugandan rollout of anti-retroviral medication, one cannot help but wonder whether psychopharmaceuticals would have dovetailed nicely to these interventions and contribute to a "projectified landscape" Their study, conducted in a rural area, occurred because the introduction of anti-retroviral therapy for HIV/AIDS treatment into Uganda in 2004, which would have likely helped to facilitate the introduction of psychopharmaceuticals, especially in an already existing "projectified landscape" (Whyte et al, 2013), where Bolton and his colleagues were not the only Hopkins research team in the area, as I discuss below.

GMH, particularly in east Africa, is also part of this "projectified landscape." As counseling in east Africa in particular becomes legible through HIV projects (Vaughan, 2016), these research trials become one of many projects from which individuals can receive health care broadly. What is different is that there are fewer mental health projects to choose from because the government clinics likely have minimal healthcare provision for mental health services (Raja et al, 2014). In implementing these trials, GMH researchers aim to conduct experimental trials to scale up and, ultimately, close the treatment gap. In doing this, however, we need to consider: what facilitates these interventions on the ground? What conceptions of illness are being treated? What kinds of ethical and temporal claims do actors use to treat these particular diseases?

CHAPTER 4: Depressive Symptomology & Experimental Ethics in GMH

Now, I want to turn to examining what helps to facilitate the implementation of GMH research interventions. Because the ethos of cost-effectiveness drives an obsession with metrics, it is important to think about the conditions of developing and measuring of these metrics. In this section, I examine the symptomology of depression, the technologies used to measure it, and the ethics that emerge in GMH interventions, specifically in non-pharmaceutical interventions, using the Bolton project in Uganda as a case study. I argue that the broader focus on symptoms than disorder facilitates an experimental ethics that sit in opposition to biomedical psychiatric practices.

To answer these questions, I want to briefly situate depression within the context of transcultural psychiatry. As historian Matthew Heaton (2014) demonstrates, depression has a long history within transcultural psychiatry, a sub-discipline with which many GMH scholars would associate or, at minimum, draw on theoretically and methodologically. In examining the role that Nigerian psychiatrists played in the globalization of psychiatry during the 1950s through the 1980s, a period marked by Nigerian decolonization and the beginning of neoliberal reform, Heaton shows that depression and its translatability is one of the main scholarly and medical concerns within transcultural psychiatry. At that time, there was a general acceptance of the universality of mental illness even if transcultural psychiatrists from the US, Canada, "they were not nearly so confident about their ability to treat those diseases with preexisting Western-

derived therapies" (Heaton, 2014: 131). Some forty years later, GMH scholars become the group that more intentionally picks this concern up and scientifically show this translation is possible.

To think about why GMH scholars are now more confident, I want to consider the movement's understanding of symptoms for two interconnected reasons. First, what GMH actors (and other medical actors like doctors, humanitarian organizations, and ministries of health) define as the problem shapes the ways in which they devise plans for treatment and intervention. Symptoms are often grouped together to create a particular pathology. This pathology, then, demands particular forms of treatment and care, which assume particular kinds of expertise, technology, and temporality. As actors define the symptoms and the ailments, they inevitably assume a particular kind of subject whose ailment is recognizable given the particular context in which healing occurs.

Second, symptoms are the means through which patients articulate their ailments. As Biehl and Moran-Thomas (2009: 273) write, "symptoms are more than contingent matters; they are, at times, a necessary condition for us to articulate a relationship to the world and to others." In other worlds, symptoms become one means through which an individual reveals the subjective experiences of the self in a medical encounter. This reflects a particular subjective experience, as Biehl and Moran-Thomas discuss, which allow those with afflictions to speak about social and bodily conditions, situated within a particular context. This subjective position, then, is "perhaps less a matter of finding a voice than establishing oneself as part of a matrix in which there is someone to hear it" (Biehl & Moran-Thomas, 2009: 282).

In addition to its high DALY scores, thinking with depression in the context of GMH becomes a case study of sorts to illuminate the relationship between GMH, psychiatry, and pharmaceuticals because depression has a slightly longer, more continuous history than other

disorders. Diagnostic categories like PTSD emerge in standardized forms in 1980 when the American Psychiatric Association published the third edition of the *Diagnostic and Statistical Manual* (Fassin & Rechtman, 2009; Leys, 2000; Young, 1995). For categories like depression, however, they underwent a different transformation: the classification for depression became a more biomedicalized definition.

Before I move on, I want to briefly describe the diagnosis of unipolar depression. Under the DSM-IV-R, depression is classified a mood disorder (APA, 2000).[2] At minimum, one of two symptoms are required: a depressed mood for most of the day, every day, for two weeks, or a loss of interest or pleasure in most of a day's activities, nearly everyday. An affected person must experience at least four more of the following symptoms nearly every day: significant weight loss or gain over two weeks, or increased or decreased appetite; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurring thoughts of death, or suicidal thoughts with or without a plan. Depression is linked to a neurochemical imbalance in the brain; as such recommended treatment is psychopharmaceuticals to restore the neurochemistry. A depressed patient can use psychotherapy in connection with medication, although because of the biological links, the latter is more frequently used.

The standardizing feature of suffering among mood disorders, and thus the standard marker for depression, is its persisting deviation from the norm. Being depressed is not inherently a pathological experience; what is abnormal is the degree and duration of the

[2] Using DSM categories is not only way to diagnose depression. Other standardized texts involve the ICD-10 (Bowker & Star, 1999), created by the WHO used widely in Europe and the Global South, and the Research Domain Criteria (RDoC), favored by the US' National Institutes of Mental Health. I use the DSM narrative because of its well-documented history within the anthropological literature as well as that it highlights quite clearly some of the shifts I aim to reveal.

depressed mood. Such change in mood must also influence other social functioning; this can include work and social relationships. Depression influences all forms of functionality. In this way, depression then is a withdrawal from the social. Depression does not require a particular event; rather, it is own a slow descent away from the constructed expectations of depressed emotions.

To examine the shifting practices around DSM-defined depression, particularly with regards to non-American populations, I examine the practices around symptom checklists often used to provide or supplement diagnoses. Broadly, symptom checklists are printed on paper and come in different lengths and formats. Physicians and other medical professionals use them as a means of receiving a possible diagnosis in a shorter amount of time. An illustrative checklist example, commonly used in GMH, is the Hopkins Symptom Checklist (HSCL). Developed in 1974 with its origins in the Cornell Medical Index developed in the 1950s, the HSCL is a three-page document, a grid with 26 rows and five columns. The columns list the symptoms individually. Each column represents the rating scale: not at all, a little, quite a bit, or extremely, which are scored on a scale of 1-4, respectively. For each symptom, a patient will rate how he or she feels for each symptom. For example, a patient could be asked, "How sad have you been in the last two weeks, on a scale of 1 to 4, 1 being not sad and 4 being very sad?" The patient then responds, "three." At the end, three scores are calculated: 1) the Anxiety Score, an average of the first section; 2) the Depression Score, an average of the second section; and 3) the Total Score, the average of all 25 questions. Having a score over 1.75 for any of the three calculations indicates the respondent is symptomatic.

When initially developed, the HSCL was standardized to psychiatric practices at the time. Following 1980, however, adapting to the DSM-III meant that it was necessary to adapt and re-

standardize psychiatric practices and documents to the now-biomedicalized definitions. This was not only true in psychiatry, but also in cross-cultural psychiatry. In a landmark 1987 paper, Harvard psychiatrist Richard Mollica and his colleagues validated a translated version of the HSCL-25 to the DSM-III. To validate it meant researchers subjected the checklist to a series of statistical analyses to test whether or not the properties of the checklist remained the same, given that the DSM-III defined disorders. In this validation, Mollica and his coauthors show that the checklist does not change despite the already-changed standards and the linguistic and cultural translation of the checklist,

Given their institutional affiliation, perhaps it is little surprise that Bolton and his colleagues used the HSCL. In Uganda, Bolton and his study team undergo a similar statistical process, validating the HSCL in Luganda, a widely spoken Ugandan language, to the DSM-IV, released in 1996. But, influenced by cultural psychiatry, Bolton and his colleagues go beyond the biomedical checklist to ask about indigenous conceptions of illness. They uncover two "depressionlike syndromes" that they used in the screening process: the interviewers "asked the responder if they thought that they had *Yo'kewkyawa* and/or *Okwekubazida*. If the person denied having either syndrome, they were not interviewed further" (Bolton et al, 2003: 3119). Despite using this as a screening mechanism based on previous research that indicated significant overlap between the two experiences, Bolton and colleagues do not describe the ways in which these two are "depressionlike." There is no sense of what may be different in terms of somatic expressions, bodily experiences, where in the body the illness is located, and importantly, what healing practices alleviated these syndromes. Yet "[b]ecause each local syndrome is only an *approximation* of depressive illness, self-report and outside reports of their presence were used in screening only and not as outcome measures" (Bolton et al, 2003: 3119; emphasis mine).

In this act of screening but not measuring, we can glean some insight into how GMH researchers think about symptoms. Here, GMH researchers recognize that individuals may have different understandings of mental illness and its symptomology. In an editorial published alongside of the 2007 *Lancet* series, the authors reminded readers "don't forget about culture!" (Bass et al, 2007). In the context of the Bolton study, these differences, at least in print, only matter in particular places, in particular, for entry into the study. In this way there is recognition of some kind of cultural specificity and overlap, but ultimately they are not ontologically the same experience. The existence of *Yo'kewkyawa* and *Okwekubazida* are recognized and do have some value within the study, but subordinated to the DSM. In this way, the hegemony of biomedical categories as a result of, at minimum, the requirements of publication.[3]

In this way, symptoms must be "testable," in that researchers must use a mechanism, here the checklist, to track the hopeful decrease in symptoms. The outcomes of the study surprised Bolton and his collaborators (2003: 3124): "Under these circumstances [of uncertainty in facilitator training], the effects of this intervention impressed us." The intervention worked. But to be impressed indicates some skepticism and hesitation that it may not work. This is, of course, because in conducting this trial, it was arguably the first of its kind on the African continent conducted by and recognized under the rubric of "global health." Given that they did not know whether the intervention would work, there is a kind of experimentality to the project (Nyugen, 2009, 2013). In conducting this test of decreasing symptomology, Bolton and his colleagues take on an "ethics of experiment," in a similar way to how Araya and his colleagues do (Han, 2013: 282). In fact, their primary goal was to see whether the international religious NGO,

[3] See Adams (2013) for, among other things, a discussion on publishing in medical and public health journals, especially *Journal for the American Medical Association* (*JAMA*), where Bolton et al (2003) is published.

WorldVision, with whom Bolton and his colleagues with university appointments collaborated, could incorporate the study into their work.

This experimentality reflects the GMH emphasis on “access to care” over “symptoms and etiology” (Bemme & D’Souza, 2014). Araya, Bolton, and Patel tack biomedical definitions for granted, even if the Bolton study used local illnesses as part of selecting participants. The experiment would have likely continued, even if they did not find any local illnesses. For Bolton and his coauthors (2003: 3124), this goal of access comes through language of impact: “We might expect even greater impact with more local experience with this approach.” The goal now is to refine the experiment to make it work even better and to go beyond Africa. The assumptions operating here are symptoms will look the same around the world, even accounting for local idioms and definitions, because of an underlying assumption about psychiatric disorder as biological (Bemme & D’Souza, 2014; Rees, 2014). Without having to worry much about tweaking symptoms or diagnostic categories, GMH practitioners can place their energy on ensuring that the intervention runs smoothly, remains true to RCT standards, and to consider how a localized intervention with positive outcomes can move beyond a clinic or a randomized set of villages.

While there is continuity with biomedical psychiatry and transcultural psychiatry through the use of particular technologies like the checklist and diagnostic categories and definitions from biomedical classification systems like the DSM, the tenth volume of the WHO's International Code of Diseases (ICD-10), or the Research Domain Criteria (RDoC), it is necessary to ask "whether GMH is deliberately creating *discontinuity* with psychiatry's institutional and conceptual infrastructure." (Bemme and D'Souza, 2014: 858). Institutionally, the Bolton study reflects a move away from the standard institutional modes as it operates

outside of formal clinical environments; the Araya and Patel studies, however, through operating in a more clinical setting, continue to reflect the spaces where psychiatry and mental health have been treated. Conceptually, it moves away from psychiatry because of the rejection of pharmaceuticals as well as the emphasis on access to care.

Here, we see a consistency in the non-use of pharmaceuticals through this truncated history of psychiatric practices operating across cultural lines. The teams led by Mollica and Bolton did not use pharmaceuticals. Patel and Araya, however, do use pharmaceuticals in their trials. Why this difference? Because, as anthropologist-physician Didier Fassin writes (2012:99), "rather than being submitted to supranational political dimensions and inscribed in an ethical order with borders, [the globalization of health] continues to be principally ruled by national interests and state sovereignties serving local constituencies." While I agree that there is a discontinuity between GMH and psychiatry – that GMH reveals, as I highlight below, that we need to question the discourses around the globalization of pharmaceuticals –the reasons for deploying pharmaceuticals in particular locations is more about the place itself than what is operating at the global space. Vikram Patel can claim to be against Big Pharma and continue to use pharmaceuticals in his research trials because it is, in part, about responding to the particular conditions.

CHAPTER 5: Theories of Pharmaceuticalization

In this section, I want to put Patel's interconnected rejection of both pharmaceuticals and psychiatry in conversation with the anthropological literature. To review, Patel rejects psychiatry because he ultimately sees pharmaceutical companies corrupting its work. This means several things. First, it shapes the kind of therapeutic interventions that GMH actors will implement. Second, it indicates the kind of expertise and knowledge that is valued within GMH circles. Here, I argue that Patel's claims and the types of interventions and knowledge that GMH actors value do not follow the expected actions of recent theorizing in medical anthropology.

First, because of favoring psychosocial talk therapy interventions over pharmaceutical trials, Patel and GMH actors do not have a "pharmaceutical-centered [vision] of public health" (Biehl, 2007: 1084). As such, GMH actors force us to rethink the pharmaceuticalization occurring around the world. Anthropologist João Biehl, in drawing attention to processes of "pharmaceuticalization" in HIV programs in Brazil, argues that network connections between health, legal, political, and corporate actors shape a world in which pharmaceuticals become the necessary and best means through which to treat individuals at the expense of a highly unequal healthcare system. Biehl's critique is that cheap pharmaceuticals become a way to manage populations, particularly the marginalized, and that by having a "pharmaceutical-centered public health" approach worldwide, the government is able to biopolitically engage in forms of dependency and subject making.

While Biehl is correct that, for certain populations, individuals are becoming increasingly governed and defined by their medications, the GMH discourses and practices raise questions about how much of a global phenomenon is pharmaceuticalization. What do we do if we are all "pharmaceutical selves" (Jenkins, 2010), whether we know it or not, yet particular global health and medical actors refuse pharmaceuticals on political economic grounds? What how do we deal with changing technologies and risk factors and blurry, ever-changing standards (Dumit, 2012) when some tools have lines for diagnosis and treatment are increasingly blurry? What do we do when some actors are, instead of providing pharmaceuticals, they are using long-standing diagnostic technologies, e.g. checklists, that have used roughly the same cut-off for years to indicate an individual's experiences as more depressed-like symptoms?

Second, the privileging of talk therapy and the rejection of the domination of pharmaceuticals within psychiatry reflects how GMH scholars are of a different mind concerning psychiatric practices. Anthropologist Tanya Luhrmann (2000) has convincingly explored how psychiatry as a discipline remains "of two minds," in tension between two therapeutic traditions. One is more biomedical, where healing comes through pharmacological treatments; the other follows the psychoanalytic traditions, where talk therapy and psychoanalysis allow patients to uncover and address the root of their illness.[4] In her book, Luhrmann argues that psychiatry experienced a shift where the biomedical forms of psychiatry became hegemonic to the longer psychoanalytic tradition. As such, pharmaceuticals come to dominate the discipline not only as

[4] Lakoff (2005) also examines similar tensions. There are several differences between the American and Argentinian psychiatrists and the GMH researchers. For both Lakoff and Luhrmann, they are exploring what happens when new ideas and technologies enter a pre-existing system. In this essay, however, the GMH scientists are trying to establish completely new infrastructures for mental health care around the world. In a way, GMH researchers avoid these concerns with the focus on infrastructure.

the primary source of treatment, but also the focus of scientific research shifts to focus on the brain than considering the social conditions of the individual.

The GMH discourse, taken with Patel's keynote as the paradigm, is disinterested the biological discourses on mental illness. While Patel argues that GMH is global health, not psychiatry, he and his co-laborers cannot escape the traditions and ideas from psychiatry given the focus of their humanitarian action: the mentally ill. GMH is not interested in conducting research on biological etiology, but is interested in health systems building (Bemme & D'Souza, 2014). There is certainly a concern for the biological within global mental health and global health writ large (Bemme & D'Souza, 2014; Rees, 2014), but the biological emerges in the construction of humanity. Brains and bodies operate the same across all humans, which facilitates, in part, for the geographic movement and translation of global health interventions. Ignoring etiological questions that pharmaceutical companies would find more interesting (and profitable), GMH can then devote its resources for designing low-cost interventions, researching how to improve health systems that do not provide much for the mentally ill, and trying to reduce the social inequalities around mental health.

In fact, "one might say that GMH has decidedly black-boxed academic psychiatry's central questions such as exact disease causation and classification, focusing instead on the language of providing 'access to care'" (Bemme and D'Souza, 2014: 858). By relying on biomedical categories, GMH scholars then look to the social determinants of poor health rather than the biological. For example, the use of symptom checklists indicates a reliance on biomedical categories, even with the often-given caveat of "we want something better, but this is the best we have right now" and the inclusion of local explanatory models and disorders. But, more central to GMH's mission, is the reduction of the "treatment gap" that focuses on the social,

not biological, causes of diseases. This black-boxing also returns us to the experimentation required to uncover the right ways to reduce the treatment gap.

While I do not disagree with Biehl, Lurhmann, and others that particular subjectivities emerge through pharmaceutical use, it is clear to me that GMH as a movement, and particular in the GMH interventions implemented in east Africa described below, and its rejection of both pharmaceuticals and parts of biomedical psychiatry asks us to reconsider how dominating these discourses are. The conversations in which Biehl, Luhrmann, and their interlocutors engaged have been productive, as they have interrogated the politics of pharmaceuticals: who has access? Who doesn't? And why? What creates the conditions for pharmaceutical use in some places, and not others? What facilitates the use of pharmaceuticals as a therapeutic regimen? There is no doubt that pharmaceutical use has increased with the influence of pharmaceutical companies in the global economy (Dumit, 2012), the move for equal access of "essential medicines" (Greene, 2011), and the political force of AIDS activism, among others. Yet despite these claims, we need to be careful of what Byron Good (2010) calls "pharmaceutical hegemony." In a sense, Good sees two "pharmaceutical hegemonies." First, pharmaceutical companies have a hegemonic influence on the globalization of psychiatric practices. Second, he sees two competing, yet hegemonic discourses in their respective academic fields, noting an irony that anthropologists see too many pharmaceuticals and the WHO in mhGAP see too few.

Given these tensions, he situates Indonesia against both of these. First, in not having access to pharmaceuticals, Good (2010: 131) argues that psychiatrists in Indonesia are "certainly drawn into and engaged in the hegemonizing processes of global pharma. But…they are also drawn into the struggle to care for difficult, psychotic patients for whom there are no magic bullets." It is not to say that pharmaceutical companies have no influence in Indonesia – Good

acknowledges they do – yet environments where pharmaceuticals are not readily available, nor are they seen as an adequate therapy by patients, temper and resist the hegemonic processes of Big Pharma. In other words, it is not possible in some places to have a "pharmaceutical-centered public health."

CHAPTER 6: GMH Out of Africa?

As noted, Bolton and his colleagues justify the use of psychosocial interventions instead of pharmaceuticals because of cost and infrastructure. Such rationale places the intervention within the realm of the political economy. In Uganda, and elsewhere in the world, economic constraints facilitate what kinds of studies GMH researchers can conduct. This, however, is not always the case. In considering the Patel and Araya studies, researchers conducted their studies in clinical settings using pharmaceuticals. India is well known for its open market for psychopharmaceuticals in both clinical and non-clinical settings (Halliburton, 2009); it has an infrastructure for generic psychiatric medications that patients can get on the street without a prescription.

As this is not the case, I want to ask: is there something about work in Africa that sheds light on why psychopharmaceutical interventions do not happen. Pharmaceuticals in Sub-Saharan African global health research are ubiquitous as a result of HIV policies and research. There has been considerable work to create spaces for HIV medications, compliance with AIDS medications, among others. For example, Bolton and his colleagues conduct the study not in Kampala, Uganda's capital, but in two rural southwestern districts, Masaka and Rakai. In 1987, Johns Hopkins and Ugandan researchers began an HIV/AIDS study in the Rakai district. Later, in 2007, the Rakai Heath Sciences Program formally opened new spaces (Rakai Heath Sciences Program, 2010). The Rakai Health Center now dispenses anti-retrial viral medication (ARVs) to reduce the HIV viral load following the 2004 rollout of the United States' President's Emergency

Plan for AIDS Relief (PEPFAR; Kunihira et al, 2010). Whether there is a direct connection between the Bolton study and the HIV work in Rakai is not known.

If we consider Brian Larkin's (2013: 329) ontology of infrastructure as the relationship between "built things, knowledge things, [and] people things," during implementation of the intervention, "built things" that could potentially facilitate a cost-effective use of psychopharmaceuticals did not exist. Offering the explanation of "high cost and limited supply infrastructure" as one reason for not using pharmaceuticals, Bolton and his colleagues (2003: 3117-8) suggest that they did not have the ability to acquire, transport, and dispense pharmaceuticals in the Rakai setting. While it seems that WorldVision had been working in Uganda for some time, what it could offer was "people things," in the form of a work force and connections to the local community at the onset of the study. Yet there are no specialized "people things" to facilitate the intervention. Psychiatrists, psychologists, and social workers are not mentioned as part of what would make pharmaceuticals a viable intervention, people who could also provide "knowledge things" about the local context. It is also possible that the latter two "things" encouraged not using pharmaceuticals.

In considering the political economy of global health research, Julie Livingston's (2012) ethnographic work on cancer in Botswana offers some parallels for considering the place of mental health and psychopharmaceuticals in Uganda. Livingston argues that cancer only become visible through HIV. Because HIV is considered a sexually transmitted disease (STD), cancer becomes a possibility through the recognition of Human Papilloma Virus, another STD that causes forms of cervical cancer. As cancer becomes recognized, oncological care providers run into the significant challenge that knowledge about cancer comes from North America and often does not mean much to oncological care in Botswana. Research studies on treatment discuss new

chemotherapy treatments, pain medications, and protocols that do not translate for Botswana because of the lack of resources. This lack of translation contributed to the conditions for improvised care: because cancer is ontologically different in Africa because of the technologies available and how it is conceptually understood, the knowledge produced in North America and the Global North does not apply equally.

Livingston provokes a number of similarities between cancer and mental health interventions in Africa. First, HIV renders the possibility of mental health research possible as well. In 2000, in contrast to the political economy and activist state in Brazil during the 1990s (Biehl, 2004) at the time of their research in Uganda, the Ugandan government had just begun ART programming on a small scale. Psychiatry had a strong presence internationally in Uganda until 1972 when Idi Amin overthrew the Ugandan government (Pringle, 2013). As such, there is no large professional presence and network for debates over the kinds of research or pharmaceuticals to emerge. Instead, it is only through other concerns and priorities, i.e. the prevalence of HIV and the existing infrastructure, that mental health comes to the surface because of Bolton and his colleagues conduct their study in a place where HIV research is going on: "[i]n 2000, we conducted a community-based survey [on depression] in an impoverished part of southwest Uganda affected by [HIV]" (Bolton et al, 2003: 3117). Genealogically, according to historian Meghan Vaughan (2016: 505), because HIV researchers began using counseling as a means through which to help HIV/AIDS patients, even before PEPFAR at Bolton and his colleagues' research indicates, mental health concerns become visible through AIDS interventions. In this way, the political economy of HIV research (which, at that time, did not include pharmaceuticals in Uganda) facilitates the possibility of research on other disorders. Such research can create new forms of connection via partnerships, as is the case with the Bolton

Study, (Crane, 2013) as well as the ways in which individuals come to live as research subjects among the broader population.

Second, in addition to being made possible through HIV, cancer and mental health are similar in the need to translate treatments. As the Bolton study indicates, the kinds of treatments and interventions possible are more mobile for mental health than for cancer. This is because talk therapies can easily travel (Nyugen, 2010). As a technology, these therapies require linguistic and cultural translation and training of community health workers, in contrast to oncological chemotherapies that require more material infrastructure to possibly be effective.[5] For Bolton, his study did not need the infrastructure of a clinical setting and existing professionalization, along with the additional storage technologies for chemotherapy drugs. This intervention is more easily implemented in low-resource settings.

Yet the Bolton study does not use drug treatments in the same way that cancer or HIV requires. Drawing on Biehl (2007), Livingston (2012: 41) writes, "pharmaceuticals, while really important, are offered in the absence of and as a replacement for hollowed out African health systems." As global health actors provide medications, especially HIV medications, these regimens become a way through which to offer medical care without having the infrastructure to attend to other needs. With both HIV and malaria, medications can help tremendously but cannot address other possible biological complications alone. Treating additional challenges, however, requires professionals in some capacity, whether doctors, nurses, or community health workers. To professionalize and have the health system infrastructure to provide employment often requires a more significant investment from international governments, national governments,

[5] This is qualified because Livingston herself is concerned with the way in which oncological research conducted in the US is not relevant and cannot take into consideration the challenges in Botswana to understand and treat cancer patients.

and philanthropic organizations. With psychosocial interventions, the same kinds of systems of professionalization are not necessary; only community health workers trained in short courses are necessary for implementation, especially if the aim is symptom reduction.

Treating mental health can fall outside of the hollowed-out health system without pharmaceuticals in a way that other illnesses cannot. Other illnesses, such as HIV and malaria, require pharmacological regimens in order properly treat someone who with the disease. Yet psychosocial interventions are being offered instead of pharmaceuticals because of not having the proper facilities and protocols. For GMH, their documents clearly state psychopharmaceuticals should not be dispensed without the requisite infrastructure. The Bolton study as well seemed to follow suit on this. As noted above, despite wanting to implement a pharmaceutical intervention, the researchers opted for a psychosocial program instead that required less funding, less infrastructure, and less actual resources, which follows the global health ethos of cost-effectiveness (Adams, 2016).

Not providing pharmaceuticals on the grounds of cost and infrastructure becomes clear this is not only a practical consideration, but also an ethical one. One possible and frequent ethical justification for not providing pharmaceuticals is because a particular culture does not accept drugs as a sufficient form of treatment.[6] This, however, is not what is going on with the Bolton study. The dispensing of drugs cannot happen under the appropriate condition, so in order to act (which is an assumed ethic), we must provide a treatment that can be equitably provided and proved effective in order to consider scaling up services. While not present in the documents, a potential logic is that in conducting psychosocial interventions, an evidence base

[6] What this does not account for is the possibility of ethnographic evidence suggesting that, for mental illness, global health has created expectations for the use of medications and to not dispense them becomes an ethical violation as a result of global health care being constituted by pharmaceuticals.

emerges that shows psychiatric care is both needed and possible. This data can serve as the political and economic justification for implementing wider services.

This is not to say that pharmaceutical and psychosocial interventions do not show up together – they certainly do. As the Patel and Araya studies from GMH indicate, alongside of Sharon Abramowitz's (2014) ethnographic work in Liberia, pharmaceuticals work in some settings and are desired despite the presence of psychosocial interventions. While Peter Locke (2015) has described the blurred lines between humanitarianism and global health, I want to differentiate here between the NGO humanitarian practices around medications in Abramowitz's text from the GMH research-interventions. The NGO, broadly, remains established as part of a health infrastructure, as minimal as it is in many places. These organizations, however, look to fill in a gap in the health infrastructure to provide care.

Because of this, although this line can be blurry at time as well, NGOs are different than other humanitarian organizations and global health actors. Humanitarian actors like Médecins Sans Frontières (MSF) that respond in crises or global health actors who come to experiment hold a different temporality and ethic because they are not inherently committed to the long-term. Those responding to crisis do not want to create formal infrastructure; they create kits and mobile forms of medical care that implemented in any kind of crisis environment (Redfield, 2013: 88-89). They can bring pharmaceuticals into environments for temporary relief if necessary. Mental health responders can come in to triage trauma and other disorders (Breslau, 2000). The infrastructure, initially, is always temporary, committed only to the present. Even if an organization remains in crisis environment longterm, there is always the possibility and constant reminder that an organization will leave (McKay, 2017).

This is different still than the temporality and ethics of experiment, where I place GMH actors and interventions. The temporality of GMH research-intervention is set for a strict period pf time, typically dictated by recourses and grant-funding. When researchers implement these psychosocial interventions, thy go in with a small-scale project with the hopes of garnering political capital and scientific results to scale services up. If both are successful, with GMH the goal is to find ways to bolster and create new forms of infrastructure, mobilized by the data at hand. But, if the funding runs out or the intervention fails, there is no commitment to any kind of permanent or temporarily infrastructure that exists. This research runs the risk of leaving new infrastructure empty, newly trained health workers without work, and the community left with reminders of experimentation (Prince, 2012).

Where the GMH and humanitarian actors like MSF overlap in relationship to infrastructure is that there is a standardization to the infrastructure (Star, 1999; Star & Lampland, 2009). While What this means in the context of psychopharmaceuticals and GMH interventions is precisely the Bolton study's abstract claim that its findings can influence other parts of Africa and beyond. But for Bolton and his coauthors, it is not about psychiatric medications moving to other parts of the world, but talk therapy alone. Their results indicate a success in reducing depression-like symptoms. With one successful study, Bolton and his fellow GMH researchers can move around the world to implement talk therapy interventions. Yet it not just Bolton's collaborators whose experiments to reduce mental health disorders by adapting a talk therapy in a new part of the world; it is hard to find any GMH research with pharmaceuticals. In this way, Bolton's study of no medications, in contrast to Araya and Patel's early studies, set the tone for future research. In many cases, it is still too early in the Movement to see what happens after the research project is complete and if Big Pharma finds new ways to capitalize of GMH's work.

CHAPTER 7: Conclusion

In this essay, I have argued that the place of pharmaceuticals in Global Mental Health is one of contradiction: a firm rejection by both the movement's architects and the intervention practices reflected in the scientific literature despite limited usage of medication in certain contexts. In this way, the process of pharmaceuticalization laid out by Biehl (2007) does not take hold in GMH projects. Vikram Patel in his speeches, along with other scholars who associate with GMH, do not have pharmaceutical-centered vision of public health when it comes to their own research on mental illness around the world. By rooting his critique of Big Pharma as a condemnation against the psychiatric establishment, Patel works to prevent any influence of pharmaceutical corporations into GMH. In wanting to move beyond pharmaceuticals, Patel and others seek to engage in a different kind of moral and political economy.

Yet as the parentheses in my title indicate, despite the strong rejection, pharmaceuticals are sparingly present in GMH practices. While the presence of pharmaceutical companies appears minimal-to-none, they are nonetheless there, if for no other reason than Patel's contextualization in his own research. The lack of pharmaceuticals exists because of GMH's rejection of pharmaceutical companies influence in psychiatry as well as their embrace of the global health paradigm of cost-effectiveness-driven metrics.

Within the contradiction, however, GMH researchers engage in practices that have their roots in pharmaceutical. From the before the codified emergence of the Movement in 2007, GMH researchers have been committed to using the Randomized Control Trial. Yet their use of

the randomized control trial to treat depression seems to be working against the original, intended goals of the RCT (Dumit, 2012). While their use reflects the RCT's use more broadly within global health (Adams, 2013), other health concerns do not have the same explicit relationship to pharmaceutical companies as mental health. In this way, one might hypothesize that GMH is using Big Pharma's own tools to show that mental health care for depression can occur without the use of medications.

Yet Patel's explicit rejection of "big pharma" and GMH's research agenda both in its policy and research publications raises particular ethical concerns. GMH's reject of psychopharmaceuticals seems to erase – or is perhaps its solution – to global unequal access to psychiatric medications. The rhetoric of cost-effectiveness still pervades, showing another space where GMH actors are deploying pharmaceutical logics against what they imagine as corporate interests. The ethics of experiment present ethical questions about commitment to research subjects, to infrastructure, and to long-term systemic mental health care for both depression and other mental disorders.

But their rejection of medications is also raises the question of who decides what is good for certain populations. Medications are used in other interventions for long-term and short-term illness. Some illnesses biologically demand "drugs for life" whereas others are constructed in ways to make pharmaceutical companies profits (Dumit, 2012). In many places around the world, GMH research operates within a "projectified landspace" (Whyte et al, 2013) where pharmaceuticals help define the terms of that landscape. Research participants may expect pharmaceuticals, only to find out they will not receive any. GMH actors might have to then navigate the murky ethical waters of their own commitments and the lived realities and existing infrastructure.

Lastly, what exactly does it mean to reject "Big Pharma"? Is it just to not use pharmaceuticals? It is to use the methods it helped to create to generate larger markets for other purposes? Or does rejecting "Big Pharma" require a larger critique that engages with structural concerns about the ways in which market logics seep into discourse? To more fully reject Big Pharma, would GMH have to articulate an ethic for action that is not rooted in other tools, i.e cost-effectiveness? Would it be to overcome the two pharmaceutical hegemonies of intervention practice and perceptions of researchers? Would it be to find new ways of creating knowledge not rooted in the randomized control trial?

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