Embodying Mental Health in Development

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Declaration

This thesis is my own work. All sources used have been acknowledged.

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Acknowledgements

By the time I graduate from the ANU in December, I will have spent five years and six months in Canberra and a semester in Paris, in which there was one transfer of programs, two degrees and three majors. The past ten months were a 'capstone,' not just for my education in Development Studies, but a continuing one towards learning how to understand and appreciate different perspectives while advancing my own viewpoints.

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Abstract

This thesis proposes a rethinking of mental health interventions in developing countries by examining policies that took place in the aftermath of the 2004 Indian Ocean tsunami in Sri Lanka, using anthropological concepts influenced by phenomenology such as the notion of embodiment. Contestations regarding the Cartesian mind-body duality have led to various methods of understanding the human being, with materialist biomedicine dominating Western psychiatry due to its scientific 'rigour.' However, Western psychiatry's universalist assumptions – a one-size-fits-all understanding of mental anguish – have failed to achieve its objectives, particularly in non-Western settings. This is because such policies thus far have maintained a biomedicine-centric stance that pathologises mental suffering, with little room for integrating local perspectives. In order to rectify mistakes, mental health professionals must understand how sufferers of mental distress process phenomena beyond solely biomedical or culturalist frames, focusing instead on the experience itself that incorporates both sides of the spectrum when necessary. I further argue that by reconsidering the meaning of experience and participation in everyday life, its conclusions can be applied to participatory development. This can take place through working together with the sufferers by encouraging their participation in formulating mental health programmes and listening to them with empathy, to find suitable emic-etic frameworks. Through promoting collaborative mental health policies as a citizenship right, the issue of 'political will' is also challenged through local community mobilisation, while re-defining the meaning of 'participation' during the process.

Introduction

Mental health in developing countries is an issue that has been receiving increasing attention in the early 21st Century. There is already a large body of literature that critiques the homogeneous, 'technical' nature of development policy; despite its claims of being apolitical, such initiatives do indeed have political effects (Ferguson 1994; Li 2007). Developing countries' mental health policies on the other hand, is a relatively new area of enquiry. Starting with the creation of 'humanitarian psychiatry' from the Armenian earthquake of 1988, mental health has been discussed and targeted by development agencies with increasing attention through initiatives such as the Movement for Global Mental Health (MGMH) (Fassin and Rechtman 2009; Lancet Global Mental Health Group 2007). Although mental health was not explicitly addressed through multilateral initiatives such as the Millennium Development Goals (MDGs), its importance on improving health inequalities between developing and developed countries has been recognised (Sachs and Sachs 2007). Triggered by a series of articles on *The Lancet* in 2007 and 2011 by Vikram Patel and his colleagues, psychiatrists have called for 'scaling up' mental health and facilities in developing countries, arguing that there is 'no health without mental health' (Lancet Global Mental Health Group 2007; Gostin 2012). As developed countries themselves start to recognise long-term issues surrounding mental health, concerns in developing countries have also increased (Chambers 2010; McEachran 2013). From the late 1980s, mental health has been a steadily growing issue in the development discourse, to the extent where it is having its own variant of the MDGs in the MGMH.

There has been a growing body of literature on mental health policy in developing countries, focusing in particular on the MGMH and its implications. Academics such as Vikram Patel (Lancet Global Mental Health Group 2007) and Arthur Kleinman (2009) emphasise MGMH's collaborative potential towards working *with*, not *for*, health professionals in developing countries towards addressing mental anguish. On the other hand, academics against the MGMH include Mills (2013, 2014), Moncrieff (2009) and Summerfield (2012), whose works focus on the impact of promulgating Western psychiatry's biomedical, materialist understanding of mental anguish, in spite of the discipline's epistemological foundations being questioned in the global North. Moncrieff (2007) and Mills (2014) in particular have been critical of MGMH and its relationship with pharmaceutical companies, as dependency on pharmaceuticals grows by promulgating a medicalised understanding of mental health; Mills' (2014) examination of farmer suicides in India exemplify such situations. Fernando (2012) and Campbell and Burgess (2012) adopt a more nuanced approach by criticising what has been hitherto a biomedicine-centric understanding towards mental anguish, while acknowledging that frameworks such as the MGMH will provide greater public awareness towards mental health issues in developing countries. Both articles stress the importance of collaboration regarding mental health policy between its practitioners and local communities, focusing in particular on understanding how communities define mental anguish and ensuring interventions are culturally sensitive. However, neither article explicitly discusses how such processes can take place without them transforming into one-sided, paternalistic

procedures, akin to the excessively malleable nature of participatory development that has been critiqued by many[1].

In response, I propose a different way to examine mental health interventions in developing countries by 'blurring' the Cartesian mind-body duality and discussing what participatory development can do to improve present and future mental health initiatives. How has the current paradigm on mental health in developing countries enabled mental health and development practitioners to design their policies in such fashion? Given its features, how can we reconfigure this paradigm to improve the status quo? This thesis first examines the 2004 Boxing Day tsunami and its implications for various Sri Lankan communities, using ethnographic evidence gathered by humanitarian workers, psychologists and psychiatrists, while providing context on Sri Lankan socio-cultural values on trauma and expressing mental distress. The second chapter evaluates the Cartesian duality and its validity in a Sri Lankan context by unpacking the case study material and examining the role of embodiment and experience regarding psychiatric interventions. The third chapter discusses finding ways to redefine 'participation' by grounding local-level projects with overarching reforms focused on greater political involvement. More precisely, I will merge what Campbell and Burgess (2012), Fernando (2012), Gaventa (2004) and Hickey and Mohan (2005) have discussed on mental health policies and participatory development, as the four articles' concepts are complementary to one another. By combining psychiatry, phenomenologically-informed concepts of the body and participatory development together, a different perspective is created from

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[1] Due to the large quantity of literature regarding the downfalls of participatory development, I will only list some articles and book chapters: Blanchet (2001); Kothari (2001); Mohan and Stokke (2000); Mosse (1994, 2001).

merging the "Three Ps." Through examining the Cartesian duality and how people encounter phenomena and process them as experiences and/or embodiments, perhaps development and mental health practitioners will be able to learn from past treatment policies in developing countries and adopt more inclusive, holistic approaches towards helping the mentally anguished by encouraging them to express their experiences without prejudice.

Chapter 1 examines mental health interventions that took place in Sri Lanka after the 2004 Boxing Day tsunami to demonstrate how aid agencies' one-size-fits-all approach towards mental health did not achieve desired outcomes. Instead of a homogeneous, universalist response to the tsunami, the heterogeneity found in survivors' coping and processing mechanisms demonstrated that the trauma-resilience dichotomy was not as discrete as psychiatrists and aid workers had anticipated (Fernando 2005, 2008; Ganesan 2006; Tribe 2007). For instance, the survivors' diverse perspectives suggested that some have used the event as a source of motivation, while others were suffering from trauma that had already been worsened by then-ongoing Sinhala-Tamil ethnic conflict (Rajkumar, Premkumar and Tharyan 2008; Lawrence 2010). Many Western mental health professionals assumed that all the survivors were traumatised, but this in fact proved to be false. This contrast between how an external party envisions a situation to be for participants and how they processed said situation shows the narrow, specific ways in which Western psychiatry has come to understand the human mind in other socio-cultural settings. Through integrating local values on mental distress in aid policies, perhaps this lens can be broadened to take into account necessary factors that were hitherto de-emphasised.

Given the narrow psychiatric perspective through which mental health interventions take place, Chapter 2 will question and 'blur' the Cartesian duality. I approach the problem of universalist discourses in psychiatry by discussing embodiment and the anthropology of experience to show the mind-body distinction is not as rigid as expected. This leaves two key questions to answer: the first one concerns the Cartesian mind-body duality, where the two entities are distinct and separate from one another, an assumption that has been kept largely intact in modern biomedicine (Horwitz 2002). While its intentions were to separate science from religious interference, its psychiatric applications do not always answer the questions that are needed (Csordas 1994). The notion of embodiment argues that the body is not a 'neutral' entity but a part of the processes through which a person experiences a given incident or process via their body (Desjarlais and Throop 2011). Put succinctly, embodiment explains how the human being senses and guides him/herself in their surroundings, leading to experiences (Aho 2008). The question of how a local audience perceives their experience of Western psychiatric and psychosocial interventions often varies between different communities. However, mental health professionals have remained adamant about their understanding of human anguish being globally accepted. As a result, Chapter 2 argues for a more holistic approach towards how people process and experience mental discomfort by challenging the Cartesian duality in Sri Lankan socio-cultural contexts.

Reconsidering the meaning of participation and inclusiveness can provide different perspectives on participatory development, an oft-derided initiative; this is what Chapter 3 will discuss. The second issue stemming from approaching psychiatry in developing countries from embodied and experiential perspectives is the exclusion of

people mental health professionals are trying to assist in the policymaking process. Finding parallels to problems associated with universalist discourses of psychiatry, many participatory development projects considered 'participation' as a panacea without considering how its processes occur. Given the various labels associated with participatory development – such as 'tyrannical' (Cooke and Kothari 2001) and a 'buzzword' simultaneously full and devoid of meaning (Cornwall and Brock 2005; McKinnon 2007) – a reconfiguration of its processes is needed. In instances of natural disasters or conflict, humanitarian aid workers have frequently assumed that they were equipped with sufficient knowledge to aid the survivors, with little consideration of local perspectives and needs (Pupavac 2002; Rajaram 2002). In response, by considering participation as a right derived from citizenship, participatory development becomes politicised from the grassroots, promoting political engagement to a wider audience and enabling communities to start engaging with policymakers (Hickey and Mohan 2005). Open, bilateral discussions are therefore needed to clearly define participation and its implications, ensuring that both development practitioners and local communities are able to exchange ideas as equals.

Merging the two ruptures together, mental health facilities are one area where participatory development can and ought to play a role. This is because mental distress is often difficult to be categorised. However, without having well-defined criteria with which to evaluate patients, identifying causes of mental distress is not easy, thus creating difficulties in finding a starting point for analysis (Csordas 1994). At the same time, Western psychiatry's preference for the Cartesian duality and biomedicine-centric analysis makes diagnoses of mental distress in developing countries difficult, due to the

ambivalent nature between the 'mind' and the 'body' across various socio-cultural contexts (Horwitz 2002). Therefore, asking local people suffering from a certain form of mental discomfort to explain their symptoms in a method that is culturally appropriate and then integrating this knowledge into Western pathological methods – an integrated emic-etic framework – can serve as a way of blending local knowledge with technical assistance (Fernando 2004, 2008; Tribe 2007). Put succinctly, development agencies have hitherto mirrored Western psychiatry's materialist stance by rendering technical – or in psychiatry's case, 'objective' and scientific – something that has a significantly subjective component: mental health. The healing process then becomes devoid of emotion, empathy and personal experience, despite humanitarian and development agency rhetoric suggesting otherwise. Even though mental distress could have affective and socio-cultural elements that cannot be answered through biomedicine and biological reasoning, development practitioners' insistence on Western grounds of rationality and mental health is likely to lead to misdiagnoses and unintended outcomes.

Chapter 1 – 2004 Boxing Day Tsunami: Interventions gone wrong

On December 26th 2004, countries in the Indian Ocean area were struck by a tsunami triggered by an underwater earthquake of magnitude 9.0, which killed approximately 35,000 people in 30 minutes; in comparison, the Liberation Tigers of Tamil Eelam (LTTE)-Sri Lankan government conflict over 20 years took 65,000 lives (Sarvananthan 2007:1). Furthermore, given the cultural significance of the time period – the full moon *poya* day – many Sri Lankans including the President were in transit when the tsunami struck, placing the country in chaos (Stirrat 2006:12). This chapter explains and discusses the varied responses to the tsunami shown by the survivors and field workers (psychiatrists, psychologists and humanitarian workers) to establish the case study examined in the thesis. It also argues that mental health interventions implemented during the post-recovery process in Sri Lanka and India failed to achieve their self-defined objectives, thereby questioning the effectiveness of psychiatric interventions in developing countries. Despite the good intentions of relief workers, overzealous funding, lack of co-ordinated action and overwhelming expectations mounted by the media on aid agencies caused problems. Without taking into account socio-cultural values and ongoing trauma from the Sinhalese-Tamil ethnic conflict, most mental health professionals who arrived in Sri Lanka adopted homogenous stances towards treating the traumatised. In doing so, what was already a disorganised relief initiative had become even more convoluted.

The Tsunami and its Consequences

The 2004 Boxing Day tsunami brought about deaths, destruction of livelihoods and infrastructure and plight upon various communities. For the survivors, having to flee

and abandon their homes brought about concerns regarding safety, access of resources and ensuring their families stayed together. In India, more than 12,400 deaths were reported, with most of the casualties coming from Tamil Nadu (Rajkumar, Premkuar and Tharyan 2008). More than 31,000 Sri Lankans were reported to have died as of February 2005, with a further 7,000 declared missing and at least 440,000 people being displaced (Yamada et al 2006). In the Aceh province of Indonesia, at least 130,000 people died, with possibly more unreported deaths with the worldwide death toll from the tsunami estimated at 280,000 (Irmansyah et al 2010:2). Over 200 organisations arrived to help the survivors, many of whom suffered from a lack of housing, food and were simultaneously exposed to somatic and mental illnesses (WHO 2005). Given the large-scale displacement of people, casualties, injuries and destroyed infrastructure, many South Asians were left with dead or missing family members and little of their livelihoods left unscathed after the tsunami. Furthermore, the geographical spread and number of organisations arriving into tsunami-affected areas posed problems in terms of mobilising human resources and addressing the various needs of survivors.

Focusing specifically on Sri Lanka, the tsunami affected all 14 coastal districts in the country. The estimated cost of direct physical damages from the tsunami was US $1 billion with $1.5 billion needed to repair said damage. From the cost of direct damages, private property damage was approximately $700 million, thus representing 70% of the total cost. Indirect losses such as reduced tourism industry and fisheries were estimated to be $250 million and $100 million respectively (ADB/JBIC/JICA/WB 2005: cited in Sarvananthan 2007:21). The eastern coastal regions such as Batticaloa, Ampara and Trincomalee were affected the most due to their proximity to Sumatra. Coincidentally,

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Batticaloa has a Tamil majority, whereas Ampara has a significant Muslim presence; significant damage also occurred in Tamil majority northern provincial districts such as Jaffna (Kuhn 2010:44-45). The extent and nature of the damages also varied greatly: although most of the casualties, environmental and physical damage occurred in eastern and southern districts, the northern districts were affected the most economically due to a lack of existing infrastructure and economic activity before the tsunami (Sarvananthan 2007). Furthermore, the ethnic and cultural diversity contributed towards the complex nature of damages incurred by Sri Lankan coastal districts ranging from fishermen losing their boats, tourist resorts being damaged and religious artefacts and sites being destroyed (Lawrence 2010; Stirrat 2006). The tsunami for Sri Lanka posed an immense challenge in terms of recovery projects, due to the large variation of not just the damages themselves, but the socio-cultural, religious and ethnic composition of regions affected by the tsunami making standardised policymaking difficult.

Sri Lankan Attitudes Towards Mental Distress: Unravelling Years of Trauma

Sri Lanka's history of guerrilla warfare and conflict had already ingrained trauma in many people's lives. From 1983 to 2005, conflict between LTTE and the Sri Lankan government caused as many as 64,000 deaths, not to mention the fear ingrained in families and individuals (Tribe 2007). Combined with additional family loss from the tsunami, it was estimated that families will need more than six months to become mentally stable again – a threshold suggested by Gray, Maguen and Litz (2004) – who emphasise the role of time in helping communities overcome their losses. Fernando's (2008) creation of the Sri Lankan Psychosocial Status – Adult Version (SLIPPS-A) criteria used to diagnose adult Sri Lankans' mental wellbeing reflected the importance of taking past

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exposures to trauma into consideration. SLIPPS-A was designed to estimate life satisfaction based on trauma exposure; those who had been exposed to both ethnic conflict and the tsunami had significantly different mean life satisfaction responses compared to those who had only been exposed to one or the other source of trauma (Fernando 2008:236). Akin to Green and Hulme's (2005) analysis of poverty as a 'chronic' temporal phenomenon, mental health in areas riddled with prior manmade or natural conflict must consider the impact of time, memory and prolonged trauma. It is possible that the families of victims are likely to have a compounded sense of anguish and loss in the instance of natural disasters and aid workers should take this into account.

The Sinhala-Tamil conflict fractured what were generally strong bonds of kinship in communities. The LTTE's recruitment and war strategies were aggressive, with threats and violence against both Tamils and Sinhala as their instruments of coercion, while martyrising those who have died conducting acts of aggression against government forces by building monuments (Daniel 1994; Lawrence 2010). Tamils typically internalise and process adverse incidents together as a family to protect each other, focusing in particular on children (Nikapota 2006; Somasundaram 2003). However, the then-ongoing war brought about 'disappearances' of various family members and displacements, which reduced family cohesiveness (Lawrence 2007; Somasundaram 2010). In response, certain families opted to 'silence' themselves to protect one another. If they talked about missing kin members, retribution from the LTTE or Sinhala forces could recur, not to mention possible relapses into panic attacks (Argenti-Pillen 2003b; Somasundaram 2003, 2010). Consequently, Tamils interviewed by Lawrence (2000, 2007) chose to discuss such issues in 'private' realms, for example religious places or even join the LTTE in search for a

'new' family. *Amman* (goddess) oracles held a special position in eastern Sri Lanka districts because of their role as envoys for receiving energy and guidance from *Ammans*, connecting with them as one to resolve conflicts, filling the void that the government had left for dispute resolutions (Lawrence 2000:180-181). As kinship became increasingly fractured from the conflict, many Tamils looked to religion or LTTE activism to replace the void, while remaining silent about abductions to protect each other.

On the other hand, the ethnic conflicts have seemingly instilled a sense of resilience and self-determination in certain communities. Decades of violence and being 'silenced' resulted in a state of 'collective trauma' for certain Sri Lankan households and individuals, who have lost family members and friends through abductions, torture and inter-ethnic conflict (Lawrence 2007; Somasundaram 2010). However, for female Udahenagama villagers in southern Sri Lanka, their accounts were primarily individualised as they sought retribution against specific perpetrators who had attacked their families (Argenti-Pillen 2007). Argenti-Pillen (2003b:162) interviewed a woman whose response focused on her new state of 'fearlessness' despite initial bouts of anguish and distress after losing her husband:

> The insurgents came in the evening, on full moon day… When they abducted [my husband], I thought "Oh Buddha, I don't know why they take him," and my heart was in shock. … Then when they had cut his neck, I lost consciousness. I stayed right next to him there, the whole night, until dawn. Now I have no fears, I can even walk over a dead body.

The interviewee was overtaken by equal parts anger and fear, to the extent where she was prepared to pursue any intruders and had accepted the prospects of death, but remained afraid of leaving her house at night. While this could be interpreted as people denying

their fears through bravado, the interviewee did not suffer from any symptoms associated with local fear-related illnesses; she was reported to be healthy. She also did not engage in rituals to remedy 'terrified hearts,' a term used to describe people intimidated by wild, violent spirits (Argenti-Pillen 2003b:161-163). In any case, the varied nature of responses towards traumatic incidents among similar ethnic, religious and cultural groups makes mental health interventions difficult to standardise. For every traumatised community and individual, there are likely to be just as many others who have used traumatic incidents as a source of resiliency.

Religion forms a major part of everyday life in Sri Lanka and must be taken into account when examining how people respond to violence. While faiths are generally affixed to certain ethnicities, this is not always the case; almost all Buddhists are Sinhalese, Hinduism is associated with Tamils, Islam with Moors or Malays but Christians are Sinhalese or Tamils (Rogers 1994:15). While Sri Lanka has a Buddhist majority in terms of religion, the areas Kuhn (2010:44-45) pointed out that were affected most severely by the tsunami have a Tamil majority of Hindus and Muslims, with a Christian minority (Tambiah 1986). As a result, mental health interventions needed to be quite specific in terms of meeting religious needs. For example, the Cartesian mind-body duality and the 'one body, one soul' identity ingrained in Christianity and Islam would not be applicable to followers of Hinduism and Buddhism, whose faiths are founded on the notion of reincarnation (Fernando 2012; Lawrence 2010). If a significant, tragic incident were to occur such as the tsunami, it was understood as 'karma' for sins committed in one's past life as shown by Radha, a Tamil survivor of Sri Lankan military torture:

I am really looking forward to my next life. I must have done some terrible things to have deserved this horrible suffering. I know that in my next birth, I will have the most wonderful life. This knowledge makes me happy (Fernando 2012:396-397).

However, certain Hindus considered suicide to be a sin and thought that God had created such a predicament for reasons they needed to discover, suggesting an impetus for resilience (Lawrence 2010:95). After the tsunami, work towards restoring religious sites of worship also took place in earnest many survivors, irrespective of ethnicity or religion, felt compelled to find places of worship in light of family and material losses (Lawrence 2010). The ambiguous trauma-resilience duality reappears in a religious context, further highlighting the importance of culturally sensitive and informed interventions.

As a result, there was a lack of 'formal' facilities to tackle mental distress brought about problems when the tsunami struck as Sri Lankan policymakers assumed, explicitly or otherwise, such support systems already existed through religious institutions. The lack of government and non-government funding towards mental health facilities was clear in areas such as Batticaloa, where no psychiatrist had been present from 1980 until 1999. Despite a two-year period between 1978 and 1980 where one psychiatrist was present in the local hospital, only monthly visits for prescription and referral purposes were available (Ganesan 2011:359). On a nationwide level, 10 out of 26 health districts had acute inpatient units in hospitals and only five medium-term rehabilitation centres were available prior to the tsunami, most of which had not refurbished their facilities from their days as 'mental asylums' (WHO 2013:78). For a population of 20 million, in Sri Lanka there were 30 psychiatrists, 3 clinical psychologists and 10 psychiatric social workers in 2001, most of whom were based in urban areas (Underhill 2002:88). Combined with the

seemingly paradoxical mixture of high mean life satisfaction rates, lack of mental health facilities and the then-ongoing ethnic conflict, Sri Lanka was ill equipped to face a nationwide level of mental distress (Budosan et al 2007). It was assumed that such issues were being resolved through social institutions such as religion and family, given the attitudes and values held by Sri Lankans across various regions.

Therefore, perhaps it is not surprising that literature from certain areas in Sri Lanka suggests that the locals considered culturally 'neutral' mental health interventions as a strange exercise. Lawrence's (2010) case study of Navalady, a fishing village in Batticaloa, illustrated how local Tamils utilized their sea goddesses not as mere idols of worship, but as fellow kin members in life who would protect them and offer advice whenever necessary. As a result, after the tsunami certain villagers who once had statues of certain sea goddesses in their houses decided not to replace them in their new homes and worship different deities instead, expressing their anger towards the damage caused by the tsunami and the sea goddess not being able to protect them (Lawrence 2010:97-98). Mahesan Ganesan (2006:243, 2011), a Sri Lankan psychiatrist, observed that local villagers in his area of Batticaloa thought that the Western mental health professionals' psychosocial projects 'offered comic relief for the survivors even though it was probably not intended as such,' whereas the mental health professionals adopted a solemn approach towards their initiatives. Culturally inappropriate interventions were not uncommon, to the extent where village leaders and religious authorities openly expressed displeasure towards mental health professionals (Wickramage 2006). Local villages have had their own mechanisms for resilience and internalising grief or pain through religious and social

institutions; if any external parties wanted to help, they should have considered what was already available.

You Don't Always Get Out What You Put In: The 'Adhocracy' of Relief Aid

In the wake of the tsunami, vast amounts of foreign aid arrived in the form of cash, humanitarian workers and material, medical and psychiatric assistance. Aid workers who were in the field focused initially on material assistance for tsunami survivors. In the coastal district of Batticaloa in Sri Lanka, the first humanitarian assistance groups who arrived primarily focused on distributing medical supplies, food and temporary housing (Galappatti 2005:65). Despite the chaos presented by the Buddhist *poya* day holidays, Sri Lankan civil society organisations were largely responsible for the initial round of relief schemes as people living in inland areas promptly arrived out to coastal areas and provided material assistance (Stirrat 2006:12). Due to annual flooding incidents and other natural disasters alongside decades of ethnic conflict, many local villages had self-sufficient disaster management mechanisms that were tested and proven, attesting to Sri Lankans' resilience and adaptability to natural disasters. Within minutes of the first wave striking the island, locals mobilised their bikes and automobiles to transport everyone at the beach near the Batticaloa lagoon to the hospital, which was the highest point in the local area (Gaasbeek 2010:125-126). Material assistance was initially an effective exercise of co-ordination by local communities; while not having experienced such a large-scale tsunami themselves, they had nonetheless endured multiple floods and other manmade conflicts to develop autonomous systems to protect people.

However, global attention on the tsunami, albeit with intentions on helping fellow humankind, caused problems for all parties involved in humanitarian assistance. The lack

of a national government presence to allocate and administer foreign assistance has been cited as a cause behind the disorganised aid responses, unlike Indonesia and India where the national governments had regulated what foreign agencies were able to bring (Stirrat 2006:11). The lack of local NGOs available to collaborate with international organisations caused problems when attempting to assign geographic areas and fields of expertise for all the organisations, eventually resulting in the United Nations taking over existing operations (Gaasbeek 2010:130; Stirrat 2006:12-13). Despite the well-tuned, utilitarian veneer of relief aid presented through the media, relief schemes in fact reflected an 'adhocracy,' reliant on impromptu decisions. Stirrat's (2006) account of humanitarian action in Sri Lanka was comparable to Dunn's (2012) observations in Georgia during 2008, especially when international NGOs had started to amass upon the island. Excessive donations and subsequent donors' expectations of using the funds 'effectively' implied that most aid projects had to adhere to Western understandings of relief action, which implied policy uniformity and consequently a lack of cross-cultural flexibility (Dunn 2012; Gaasbeek 2010). Put succinctly, humanitarian sentiments became overbearing due to the excess amount of donations, a lack of local NGOs with whom relief package co-ordination could be organised and media pressure to utilise funds in a way deemed appropriate by the donors.

One example of the inefficient relief schemes is the Sri Lankan government's housing re-establishment scheme. In response to the growing number of uninhabitable housing in the wake of the tsunami, the government introduced compensation funding of up to 250,000 Sri Lankan rupees (SL Rs.) for destroyed homes and SL Rs. 100,000 for damaged ones. However, the funding went to homeowners, not necessarily tenants, with

no compensation available for damaged goods inside the house. Furthermore, in the Balapitiya region, there were 713 fully damaged houses; given that the Housing Authority on average construct 100 to 200 houses annually, this posed logistical and manpower problems as the Authority was facing an unprecedented number of jobs to complete (Gamburd 2010:68-69). Ashok, a public servant interviewed by Gamburd (2010:69), had the following to say:

> I can't like all of the way things were done… The government should have looked after the people whose houses were fully destroyed first. … They have helped the people whose houses were half damaged and they are now fully restored, while a lot of people who lost everything are still in plank houses.

With little consideration to village or town-specific situations and resource – both human and inanimate – constraints, the recovery process slowed down to the extent where those who were guaranteed housing were still living in temporary shelters in mid-2005. Even with families whose houses were built, some were still living in shelters as their families were too large (Gamburd 2010:69-70). Similar to the homogenous, saturated situation international actors had created in regards to humanitarian assistance, the Sri Lankan government's housing scheme in the Balapitiya region showed that the one-size-fits-all approach was not working, and that a tailored, collaborative framework was needed.

Post-Tsunami Mental Health Interventions: Drowning in Trauma?

In the wake of the tsunami, foreign psychiatrists and doctors had predicted that the Boxing Day tsunami would leave Sri Lanka with a prolonged state of trauma, with severe long-term effects. Given the lack of mental health facilities in Sri Lanka, Western psychiatrists and doctors expressed concern at the potential of chronic depression and

Post-traumatic Stress Disorder (PTSD) affecting survivors' mental states (Galappatti 2005; Watters 2010:69). Unlike Fassin and Rechtman's (2009:163-169) recollection of humanitarian psychiatry in Armenia after the 1988 earthquake, most requests for psychiatric relief aid in Sri Lanka came from foreigners. Notions of compassion towards fellow compatriots were deemed unnecessary, as the concept of 'trauma' became widespread and steadfastly quasi-universal through one of its subsets, PTSD (Fassin and Rechtman 2009; Young 1993). Unequipped and caught unaware of the tsunami, in the eyes of mental health professionals Sri Lanka was about to face a nation-wide level of trauma. According to Western mental health professionals, the spread of trauma – in particular PTSD – was deemed to be a near certainty in Sri Lanka and action would need to be taken immediately (Watters 2010:69-70). The near-consensus agreement from Western psychiatrists and doctors with no socio-cultural connections to Sri Lanka declaring a national endemic-esque prevalence of PTSD demonstrates how it has become widely accepted in mental health discourse. Even without taking cultural variation into account, implicit universalist assumptions made about the tsunami survivors as sufferers of PTSD suggests its cross-cultural validity is now taken for granted.

Therefore, perhaps it is not surprising that psychiatric interventions in Sri Lanka followed a similar vein to other forms of humanitarian intervention taking place. Debra Wentz, executive director of the New Jersey Association of Mental Health Agencies, was on holiday in Sri Lanka when the tsunami struck. Watters (2010:67-68) describes the course of action Wentz took after having witnessed the tsunami in its path of destruction:

> Initially she focused on alerting the drug companies she worked with to the medical needs of the
> population. She then turned her efforts to alerting the Sri Lankan population about the
> devastating psychological impact that would soon be felt. … In an interview that ran repeatedly

on Sri Lankan national television in the days and weeks after the tsunami, Wentz told the

population of how the symptoms of PTSD cluster… she advised everyone to be on the lookout

for this pathological behavio[u]r in both adults and children.

However, psychiatric professionals at the University of Colombo (2005) had issued a statement regarding the forthcoming mental health interventions, which ended up being overlooked by many Western organisations. They reminded foreign mental health professionals that the survivors' responses 'are ordinary human reactions to a crisis' and that they ought to 'attend to what the *affected people* are signalling by this distress' (University of Colombo Faculty 2005, emphasis kept). While Western assistance was appreciated and needed due to a lack of existing mental health facilities in Sri Lanka, their resources should be allocated carefully in a collaborative manner. Without having a sound appreciation of Sri Lankan cultural values, Wentz implicitly assumed that Sri Lankans were as equally susceptible to PTSD symptoms as Western countries, reflecting a widely-espoused assumption held by many Western mental health practitioners and trauma specialists. Despite Wentz's intentions towards minimizing trauma among local communities through prompt action, they took place under assumptions, not necessarily through empirical evidence.

Furthermore, the hyper-competitive nature exhibited by international NGOs also continued onto mental health interventions. A significant majority of psychosocial and psychiatric programmes targeted Sri Lankan children, due to their relative vulnerability to their surroundings compared to adults. However, Ganesan (2006:245) noticed a certain trend among the mental health professionals in their activities:

It was common for the [facilitators] to differentiate between 'our' children and 'their' children. At times children were asked not to play with children belonging to other groups. This often led to conflicts… and at times brought about animosity between the children themselves.

The Othering of children by NGOs, even in natural disaster settings, suggests an explicit desire towards gaining recognition from their donors about undertaking substantial work. As Ganesan (2006) commented above, instead of providing allegedly 'better' treatment to children, the competitive nature of NGOs had created schisms between them, thus further deteriorating what were already fragile mental states from fractured family ties. Regardless of the final outcome, provided they could appease the Western public eye in their actions and maximise positive publicity, the NGOs competed with one another to 'heal' as many children as possible.

Conclusion

The 2004 Boxing Day tsunami had an immense impact on Sri Lankan society. Local communities demonstrated experience and resilience in their responses to the natural destruction left after the tsunami; the initial responses to the disaster were primarily led by them, with relatively little assistance provided by external organisations. However, once the deluge of international governmental and non-governmental actors arrived in Sri Lanka with an exorbitant sum of funds and resources at their disposal, humanitarian intentions transformed into a hyper-competitive environment based on building one's reputation instead of livelihoods for tsunami survivors. It is not surprising that mental health interventions took a similar course to other strands of humanitarian action, considering the lack of consultation and an abundance of culturally insensitive mental health policies that took place. Similar to humanitarian actors' sincere intentions being mistranslated in practice, the imposition of PTSD on the survivors led to more

confusion and misunderstandings surrounding mental health interventions. There are some analytical points to be considered from the erroneous practices adopted by mental health professionals; the first point, discussed in the next chapter, critiques how Western mental health professionals adopt a universalist understanding of human beings and how they experience mental distress through the Cartesian duality.

Chapter 2 – Blurring the Cartesian Duality: Embodying Anguish

The Cartesian duality is where the human body is divided into two components: the mind and the body. In Western contexts, this duality was generally assumed to hold for everyone, although it has now been contested by many[2]; the mind and the body are not always considered as two distinct entities in one physical 'being.' In various socio-cultural settings, the relationship between the mind and the body can take different courses. Mental distress cannot be solely attributed to chemical imbalances in the brain; the surrounding environment can play equally significant roles in creating and perpetuating anguish. This chapter explains how Sri Lankans interviewed by various mental health professionals and anthropologists processed 'trauma' after the 2004 Boxing Day tsunami, then demonstrate that the Cartesian duality is not as clear cut as many mental health professionals expected. Despite assumptions of quasi-universal traumatisation amongst the survivors, ethnographic evidence collected by anthropologists and various mental health professionals suggest otherwise. Furthermore, the impact of Tamil and Sinhalese ethnic conflict played a significant role in how survivors processed mental anguish, illustrating the importance of socio-political contexts. While the Western psychiatric lens is useful in finding correlations between abnormalities in bodily functions and social behaviour, it is not the only means to examine mental suffering. Through unpacking the links between the human body and how people experience and harness phenomena in everyday life, we come to understand the human being as an agential body

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[2] Similar to critiques of participatory development, the Cartesian duality has also been challenged by many. To name some references: Jackson (1994); Leder (1984, 1992); Lyon (1997); Scheper-Hughes and Lock (1987).

that influences and is influenced by various social and biological factors, instead of solely subscribing to biological determinism.

The Mindful Body, the Embodied Mind and the Lived-Body: Rethinking Pain

The Cartesian mind-body duality traces back its origins to an enquiry seeking to separate religion from science; in doing so it however created a set of power relations. René Descartes' definitions of the corporeal and the incorporeal is such that the body – *res extensa* – was deemed to be devoid of intelligence and autonomy, because such tasks were assigned to the mind – *res cogitans* – which represented the 'essence of self and the divine aspect of the human being' (Leder 1984:29). The body was therefore akin to a machine or a mathematical equation that could be decomposed and 'solved,' opening up the possibility of compartmentalizing body parts and conducting positivist analyses that underpin the study of human anatomy (Leder 1984:30). It is through this Cartesian tradition that modern medicine and enquiries on the human mind began to develop. Foucault's (1963, 1975) discussion of modern medicine's origins stemmed from the French royalty's need to monitor and eliminate those who prescribed false medicines, thus exploiting the ill. A centralized, unified body of knowledge to determine what is normal and what is pathological was therefore required to distinguish between 'real' and 'false' medicine, thereby fostering a positivist understanding of the human anatomy through the 'clinical gaze' (Foucault 1963). As a result, knowledge started to play a role in power relations between those who create said knowledge and its 'field' and those who apply it; thus the power-knowledge relationship began to manifest itself (Foucault 1963; 1975).

In response, Descartes' rigid division between the mind and the body and their influences on human activity has been critiqued. There is more to human movement than determinism; the body is the first point of contact between the person and their physical surroundings. The concept of 'experience' starts from the physical body and its actions and sensations are then interpreted and analysed by the individual. Put succinctly, human experiences are defined using the ability of sensing and moving within one's surroundings (Jackson 1998:18-19; Leder 1984:31-32). Scheper-Hughes and Lock's (1987) discussion of a 'mindful body' challenged the Cartesian duality, by showing that the mind-body distinction is not as discrete as expected in non-Western cultural settings. There is more to the 'body' than its physical, tangible form: social bodies and the body politic also exist, where the individual influences and is influenced by their surroundings (Desjarlais and Throop 2011:89; Scheper-Hughes and Lock 1987:8; Ten Have 1995). These 'bodies' then interact with one another to define the experience of human distress, with one application being the separation of diseases – a set of generalised statements – from illnesses – the personal features of human anguish. However, this process deemphasised the political and collective aspects of describing human illnesses and prioritised instead the individualised, biomedical lens (Scheper-Hughes and Lock 1987:9-10). Therefore, the concept of human suffering needs to be reconfigured to encompass a more holistic understanding of how people's senses, movements and thoughts affect and are affected by said suffering.

The 'lived-body' and its avenues of expression – one example being emotions – is what scholars influenced by phenomenology propose as a different way to understand the human being and most importantly, their experiences. Understanding people as lived-

bodies harnesses 'the very [centre] of one's experience, moods, expressions and projects,' instead of treating them as deterministic physical entities, open to being controlled by one's own mind or others' (Leder 1984:36). Instead of focusing exclusively on the rigid boundaries between bodily and cognitive functions, an approach discussing emotions and how they are formed can show the human body as a 'whole,' interacting with its surroundings (Lyon 1997; Lyon and Barbalet 1994). This is because emotions operate 'in social processes as the basis of agency'; its role is to facilitate and underpin decision-making processes and subsequent actions (Lyon and Barbalet 1994:50). Aho's (2008:244) application of phenomenology in psychiatry aims to expand the definitions of the Self as an exclusively biological entity and recognise how 'our experience of things… is shaped by the sociohistorical situation into which we grow.' An example of such an analysis is Corin's (2007) discussion of psychosis and schizophrenia in Montreal that focused on treating symptoms as phenomena, representative of how people experience distress. Given how mental distress can be communicated through not just language but also emotions and other bodily functions, focusing on their role in mental health as a separate entity from biological or socio-cultural determinants provides greater depth towards understanding how mental distress is processed and experienced by people.

As a result, the notion of 'pain' becomes broadened. Sufferers can make distinctions between mental and physical pain, adhering to the Cartesian duality. However, when the source of the pain remains ambiguous or multiple sources have been identified, then the Cartesian duality becomes blurred and one ends up with the 'experience' of pain and suffering (Jackson 1994:210). Secondly, pain cannot be measured using an objective scale; it is up to the sufferer to confirm whether they are

experiencing it and occasionally identify its origins, but they are unable to determine whether their suffering is greater than someone else's (Jackson 1994:213). Furthermore, pain cannot always be communicated in a way that all parties involved will comprehend as certain aspects may not be able to be described accurately using the body (Scarry 1985:4). Nancy Scheper-Hughes' (1992) account of infant mortality, maternal health and violence in Brazil sheds light on the complexity of the mind-body relationship on illnesses. Despite numerous visits, one of Scheper-Hughes' (1992:181) interviewees said that the doctors 'never told me what was wrong… They just kept sending me home with [remedies] for my heart.' Given the materialist focus of biomedicine and biology and its subsequent division of the mind and the body as two separate entities, it is perhaps not surprising that the doctors of Alto do Cruzeiro were unable to differentiate between *nervos* (pain from the head due to chronic hunger) and *fome* (pain from hunger itself in the stomach) (Scheper-Hughes and Lock 1987; Scheper-Hughes 1992). 'Pain' then becomes more ambiguous and not necessarily restricted uniquely to the mind or the body, but revolves around the sufferer's existence. Combined with temporal dimensions, pain becomes harder to trace and is felt 'everywhere' by the sufferer.

The concept of 'social' illness should then be considered by medical and development practitioners in order to understand local understandings towards a certain phenomenon – in this instance, mental anguish. Scheper-Hughes (1992:195) describes social illness in her observations as something 'that has gathered around the primary experience of chronic hunger,' which spreads from the stomach to various parts of the human body, eventually leading to migraines and a sensation of weak legs – this belief stems from the residents' understanding that all the veins in the body are connected to

one another and are identical, regardless of their location. The chronic nature of poverty has brought about hunger and its lasting consequences are expressed through headaches, catatonic behaviour and a sense of weakness enveloping the body. The role of social capital as a positive determinant of improved mental health (Harpham et al 2004) could be questioned as the residents interacted with one another on a frequent basis, discussing the sources of their pain and their durations (Scheper-Hughes 1992). Since poverty in the 'Alto' is widespread, these symptoms of *nervos* became endemic among the residents, thereby making it a 'social' illness. Approaching diseases in this manner integrates local perceptions regarding illness and its effects on society and vice versa, providing a different viewpoint to that of medical staff.

Why Biomedicine? Why Materialism? The Ivory Tower of Mental Health

Psychiatry's consistency and accuracy in treating those suffering from mental distress remains contested. Rosenhan's (1973) experiment on pseudopatients – that is, people who pretended to be mentally ill – served as one example of psychiatry's "dogmatic" nature, as the participants had to exhibit certain demeanours in order to be declared 'clinically sane' and therefore discharged from institutions. Henrich, Heine and Norenzayan (2010) argue that psychological research overly fixates on results from "WEIRD" (Western, Educated, Industrialised, Rich and Democratic) countries and assumes that the rest of the world behaves in a similar fashion. They examined various cognitive functions such as spatial analysis and IQ heritability, concluding that persons from WEIRD countries were the least representative ones for the global sample. The division of 'neurosis' as a nosological category into two axes in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) – Axis I represented

quantifiable, 'real' illnesses that could be addressed promptly using pharmaceuticals, while Axis II was defined as illnesses that were best resolved through religious or philosophical activities – illustrated gaps in psychiatric literature that could not be explained through the biomedical lens (Aho 2008:245). Western psychiatry, like all other branches of knowledge, is a constantly evolving and changing one. However, its adamant stance on the cross-cultural validity of its nosology seems unchanged.

The origins of psychiatry's universalist stance can be found from the discipline's focus on biological functions, as they could be empirically verified across many people. Descartes' intentions to define the body as a subject of enquiry and the mind as something that God bestows upon people defined modern science, as it became increasingly fixated on materialist understandings of the human body (Leder 1984; Ten Have 1995). Consequently, increasing neuroscience funding and continuous examinations of the human anatomy provided the biological foundations for psychiatric research: the human brain. This is because its fundamental features largely remain the same across various ethnicities, genders and different cultural settings (Horwitz 2002:136). Combined with the emergence of genetics as a growing area of enquiry in biology, evolutionary psychology received greater attention as psychiatrists aimed towards establishing empirical, scientific credibility in their discipline by using materialist analyses of human behaviour (Horwitz 2002:132-133). Using this discipline's line of argumentation, mental distress is understood as an 'illness,' attributed to chemical imbalances in the brain. Given the quasi-identical nature of this organ, mental illnesses occur to anyone, anywhere and can be understood in a single, identical manner, resembling the 'partial analysis' method used for somatic illnesses (Foucault 1963; Mills 2013:5). By defining the human brain as

the foundation from which all mental distress stems, Western psychiatry resembles its medical counterparts by mimicking their grounds of legitimacy and applying them to mental discomfort.

However, the pathologization of mental distress – defining mental distress to be an 'illness' – creates stigma not only for the distressed, but also among development practitioners. The World Health Organization (2010) states stigma towards the mentally ill as one of the main hindrances toward improving mental health. However, social prejudice starts by problematizing mental distress as a 'disease' instead of another term such as a 'challenge,' as such labels increase the social burden of mental distress on sufferers and their families (Lachal 2003:5). The pathological and nosological expansions of mental illness has created issues such as misdiagnoses, where non-governmental organisations (NGOs) have made guidelines on how to spot the mentally 'ill' or 'insane' (Mills 2014:61-64). This is a 'double-edged sword' outcome: on one hand people could assist those in need by identifying their symptoms, but it could also be used to legitimise societal exclusion by creating unequal power relations against minority groups in society, while boosting profits of the pharmaceutical industry (Fassin and Rechtman 2009; Mills 2014; Smith 2002). Combined with the aforementioned problems of technical assistance and the problematisation of mental distress as an illness, the domination of Western-influenced universalist discourses in psychiatry has caused issues of cultural insensitivity and treatment inefficacies in developing countries. Despite contestations against the Cartesian duality by anthropologists, psychiatrists and other mental health personnel maintain their materialist, biomedicine-centric ways due to the casual relationship

between abnormal trends from the brain and human behaviour being proposed by Western psychiatric research.

One possible reason for psychiatry's materialist-centric stance stems from the political economy of pharmaceuticals [3] – put succinctly, the profitability of pharmaceutical market expansion into developing countries. Mills (2013, 2014) likens the MGMH's proposal to 'scale-up' mental health facilities and medications to colonisation of the global South, as developing countries have no means to express their opinions. Given the contested nature of psychiatry and the validity of its treatment methods entailing alterations of brain chemicals by drug intoxication – in other words, consuming psychotropic substances – it is bizarre that the methods being criticised in the global North are being unquestioned in its applications in the global South via MGMH initiatives (Bemme and D'Souza 2012; Moncrieff 2009; Summerfield 2012). Instead of defining their projects as 'interventions,' MGMH proponents perceive their work as 'treatment,' formulating their criteria of normal and abnormal behaviour on Western psychiatry and eliminating any means of cooperation or even cross-cultural communication (Mills 2013:8). Despite what GMH advocates have stated regarding their openness towards cooperating with the global South (Bemme and D'Souza 2012; Lancet Global Mental Health Group 2007), their projects and rhetoric thus far indicate otherwise. Until Western psychiatrists acknowledge the plural nature of understanding the human experience beyond their materialist-centric norms, such rifts will remain.

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[3] I intend to discuss this topic briefly for the purpose of completeness; the focal points of this thesis lie elsewhere.

Pharmaceutical companies are aware of the potential profitability of biomedicine in developing countries. For example, profits for certain products greatly outweigh fines from companies' illegal activities: Wilson (2010; cited in Mills 2014:43) reported that AstraZeneca received $21.6 billion in revenue from Seroquel, an anti-psychotic; in contrast, the company was fined $520 million for false advertising. As pharmaceutical firms argue for their products as solutions for societal problems, more people increasingly take psychotropic medications (Jenkins 2011; Lakoff 2005), a phenomenon mirrored in Mills' (2014) study of mental health policy in India. The inability to affect world crop prices is cited as one of the primary determinants of suicide among Indian farmers, as they are subject to price fluctuations that affect their revenue. However, local NGOs and government health officials have attributed the suicides to individual issues such as chemical imbalances in the brain, without considering the macro-level situation in which the farmers find themselves: varying crop prices, indebtedness and no government support (Ecks and Basu 2009; Mills 2014:36-41). Coincidentally or perhaps unsurprisingly, antidepressants are a viable source of revenue for pharmaceutical companies in India: a study in 2005 revealed that 77% of surveyed Indian pharmacies stocked Prozac, a higher rate than Ibuprofen, household painkiller (Mills 2014; Tsao 2009:2). Having witnessed increasing revenue in the developed world, pharmaceutical companies have started to expand their operations into countries hitherto left unexposed to Western psychiatric methods such as psychotropic medicine. They have already started to amass significant revenue and profit from their pharmaceutical products and continue to do so.

As a result, grounding one's analysis solely on biomedicine or psychosocial perspectives should be avoided to prioritise patients' experiences of mental anguish. Instead of relying on the DSM – whose definition of mental illness primarily focuses on biological and Western socio-cultural aspects that are resolved through biomedicine – as the absolute authority on mental distress, by encouraging patients to describe their own experiences and perspectives regarding the suffering they have endured, they are treated as a complex entity influenced not only by biological factors, but also the world in which they live (Aho 2008:245). If doctors were to omit the patient's 'being-in-the-world' – this could be their personal history, lifestyle, general behaviour and interpersonal relationships – when examining them, it is possible that they will overlook socio-cultural variables that affect their patient (Leder 1984:37). As Davis (2000: cited in Das and Das 2007:69) summarises, evaluations of medical systems should not only consider the effectiveness of medical interventions, but also 'what they allow people to say,' thus focusing on a collaborative doctor-patient relationship grounded in the patient's recollections of their experiences. Attempts at treating mental anguish should first focus on the patient's understanding of pain; relabelling one notion of mental illness as another does not shed light, but instead repackages an unanswered question.

However, the disparities between multiple approaches towards mental distress – in particular those between local communities and external development agencies – poses problems on which perspective is more 'accurate' in assessing the needs of people. Although attempts at 'transcultural psychiatry' have taken place and demonstrated the importance of taking cultural variation into account (Bhui 2011; Kiev 1972; Kleinman 1988), such sentiments do not seem to have been ingrained or shared by all development

practitioners working in mental health. Through perceiving developing countries as 'somehow categorically and intrinsically different from [developed countries],' a dichotomy of the 'Self' and the 'Other' is created. Consequently, 'we' believe that 'they' are different, even before getting to know 'their' socio-cultural values (Richter 2004: 446). This is mostly due to the differences between how psychiatrists, psychologists and development practitioners perceive mental health in a development context, which further disrupts reconciliation between and within theory and practice (Desjarlais et al 1995; Sugar, Kleinman and Heggenhougen 1994). There are disputes between psychiatrists and psychologists who maintain a culture and context-specific approach towards treating mental illnesses – thus suggesting heterogeneity in psychiatric treatment (Bracken, Giller and Summerfield 1995; Miller 1999; Young 1993) – and those who adopt a universalist stance, where everyone reacts to a given phenomenon in the same manner (Horwitz 2002; Kiev 1972). The contested nature of understanding the human mind has subsequently resulted in policymaking marred by ambiguity, failing to achieve self-defined objectives.

Applications in Wake of the Boxing Day Tsunami

In Chapter 1 I argued that many mental health interventions formulated by psychiatrists failed to achieve their goals, but they nonetheless persisted. This is because psychiatrists, not psychologists, were initially preferred in humanitarian settings due to their training in medicine; such preferences have remained over time. Doctors and psychiatrists shared the common language of a materialist, biomedicine-centric understanding of the human body, reducing the possibility of misunderstandings. Consequently, a psychiatrist interviewed by Fassin and Rechtman (2009:167) who participated in humanitarian relief work in Armenia during 1988 was suggested to join

her colleagues while at Médecins sans frontières (MSF), as psychiatrists were qualified doctors and able to prescribe pharmaceuticals. Since humanitarian interventions had hitherto primarily focused on material assistance and resolving physical maladies, medical staff requested personnel who were capable of understanding Western medical language when the suggestion of mental health interventions arose in MSF discussions. Furthermore, time constraints posed in humanitarian contexts often leave little time available for on-site discussions, with organisations focusing more time on efficient ways to mobilise resources and personnel (Fassin and Rechtman 2009:167-168). Therefore, what had initially become a decision based on time constraints and 'convenience' became gradually taken for granted in future humanitarian projects, as observed by Pupavac (2002) in her case study of psychosocial intervention in Kosovo and other cases of humanitarian psychiatry in Palestine as documented by Fassin and Rechtman (2009) and Sri Lanka, as shown in the previous chapter.

Mental health concepts grounded in Western psychiatry are also preferred by development practitioners, as they could explain mental anguish through materialist reasoning that could be solved through technical assistance, such as providing psychotropic pills. Mental distress poses difficulties when attempting to provide qualitative variables to define the concept. For instance, the DSM has been accused of forcing normalisation onto heterogeneous issues such as trauma through the term PTSD (Summerfield 1999). Young (1993) and Summerfield (1999, 2001) argue that PTSD is a social construct by demonstrating how Americentric DSM definitions of the disease fail to correctly diagnose certain non-American patients, citing arbitrary criteria for symptom durations and the conflation of hardship with mental illness. Given the label's origin as a

means to categorise American veterans from the Vietnam War, the validity of PTSD as a diagnostic tool is primarily confined to patients from a European or European-American cultural background (Young 1993). Therefore, its universal usage to designate any patient with trauma-associated symptoms may pose problems in other cultural contexts (Hinton and Lewis-Fernandez 2010). However, narrow, specific definitions such as PTSD make development practitioners' oft-preferred means of intervention – technical assistance – easier to justify, as they could cite Western psychiatric research as evidence (Li 2007). Ultimately, contestations over definitions of mental health make it a difficult concept to define, unless one utilises psychiatric research that attributes abnormal human behaviour to chemical imbalances in the brain. This suggests one possible reason why psychiatry's materialist foundations were looked upon favourably, as casual relations could be suggested.

However, the usage of PTSD for all trauma-related mental health issues in developing countries is a problematic initiative. It was estimated that 14% to 39% of Sri Lankan children examined were suffering from PTSD four to five weeks after the tsunami, based on criteria developed in North America (Neuner et al 2006). However, PTSD literature often states that symptoms are likely to appear in the first three to six months after traumatic incidents, thus questioning the validity of Neuner et al's (2006) results; the pathologisation of people's reactions to tragic incidents can lead to hasty conclusions such as this one (University of Colombo Faculty 2005; Watters 2010:70-71). Furthermore, trauma in a Sri Lankan context is not always solely felt from a personal level; given the interconnectedness of family members and within the local community, the coexistence of community-wide, district-wide and even region-wide trauma alongside personal grief

are plausible scenarios, akin to how Cambodia has been labelled a nation of trauma from its Khmer Rouge period (Boulet 2009; Fernando 2009; Somasundaram 2010). Therefore, how Sri Lankans respond to trauma could be different to the patterns observed from Westerners; treating the former group using standard PTSD criteria influenced by the Cartesian duality may lead to unintended consequences that further disrupt their mental wellbeing.

On the other hand, mental health interventions led by expatriate psychiatrists focusing on guiding tsunami survivors to express their experiences in culturally appropriate settings showed greater potential than culturally 'neutral' interventions. Ganesan (2006, 2011) and Fernando (2008, 2009) explain their position as cross-cultural and linguistic interpreters: their fluency in Sinhalese, most commonly spoken language in Sri Lanka, and sound understanding of Sri Lankan socio-cultural values helped their initiatives towards re-establishing effective mental health facilities. While telling one's trauma accounts to an impartial therapist with no common cultural ties may seem intimidating, sharing one's experiences – instead of merely reciting 'signs' of mental illness – with fellow survivors fostered a sense of togetherness that many survivors had sought after losing family members from ethnic conflicts or the tsunami (Fernando 2009). By encouraging mental health professionals with local ties to come back, as seen by the first documented account of humanitarian psychiatry during the Armenian earthquake in 1988, they were able to relate to the survivors' needs and able to understand their recollections and embodiments of the tsunami in a culturally appropriate manner (Fassin and Rechtman 2009:167-170; Ganesan 2011). By evoking the personal connection one has with their motherland and home culture, mental health personnel were able to provide

culturally informed interventions that helped those in need, instead of primarily relying on biomedical interventions influenced from the Cartesian binary.

In fact, it is through such mental health professionals through whom the tsunami survivors were able to communicate with ease compared to Western mental health personnel. Spivak's concept of the 'native informant' can be extrapolated into this context (Kapoor 2004), where people from the same 'imagined community,' à la Anderson (1991), can empathize with one another without necessarily having to verbally express their sentiments. It is through their common socio-cultural background that expressions of mental trauma can be reinterpreted as experiences endured by beings-in-the-world. In Batticaloa, Ganesan (2011) encouraged the tsunami survivors to consult local Ayurvedic healers as well as his psychiatric profession, having been aware of the medical pluralism described by Tribe (2007); word had eventually spread over to the healers themselves about this proposal and the healers themselves also referred their clients to seek psychiatric assistance when they deemed problems to be mentally related, instead of being linked with deities. Fernando (2009) on the other hand consulted a parish priest, who helped find group therapy participants; having intimate knowledge of the prospective participants' experiences and personalities helped create ideal social dynamics. Both Ganesan and Fernando were aware of the role of religion and local healers in Sri Lankan society and integrated emic views towards religion and medical pluralism with the etic – Western psychiatric treatments. Through treating the survivors' recollections and symptoms of trauma as experiences understood under 'familiar' local socio-cultural settings, mental distress is not being pathologised under Western psychiatry. Instead, they

are considered as phenomena that are being resolved under local terms through a deliberative, inclusive process.

However, finding expatriate psychologists and psychiatrists and assuming that they will always carry out culturally sensitive treatment plans is an ill-advised assumption. Put succinctly, native informants are not a panacea for mental health policies in developing countries. Spivak cautions overreliance on native informants, as they are no less susceptible to external interests than the Other examining a local community (Kapoor 2004). It is not uncommon for pharmaceutical firms to sponsor psychiatric and psychosocial conferences; Pfizer sponsored one about the Sri Lankan tsunami, titled 'After the Tsunami: Mental Health Challenges to the Community for Today and Tomorrow' (Watters 2010:80). One of the papers presented at the conference was by Davidson (2006), who reported that after four weeks of consuming Zoloft, a Pfizer-produced antidepressant, his test participants' trauma recurrence levels started to decrease. However, in the article he states that Zoloft had not been certified by the Food and Drug Administration for PTSD treatment. While no Sri Lankan psychiatrists were reported to have participated in the conference, Kapoor's (2004) application of Spivak's ideas serves a cautionary tale in conflicts of interest for mental health professionals, as they need to be capable of examining and critiquing their actions. Finding someone who knows the local socio-cultural values and languages – to ensure that mistranslations are minimised – and adapts their psychiatric toolkit accordingly is what is needed.

In any case, being aware of how past practices have affected mental health and knowing which new technologies to use is an important aspect of improving global mental health. Patel and Kleinman (2003) argue that the most effective mental health treatment

projects in developing countries were created by practitioners who not only adapted their knowledge with socio-cultural values espoused by their patients, but also continually worked on doctor-client relations. Essentially, those who conduct multiple, frequent self-evaluations and adapt accordingly, on average, were able to meet the needs of their patients more effectively than those who did not adopt such practises. Similarly, Bhui (2011:91) discusses how psychiatrists 'often talk about patients' cultures but rarely about those of the professionals; yet professionals' awareness of their own cultural histories and influences is at the heart of understanding the cultural interplay in therapeutic encounters.' While the majority of attention towards mental health in developing countries is allocated towards the patients' needs and cultural backgrounds, the aforementioned excerpts suggest that a greater focus ought to be made towards how mental health professionals evaluate their own practices.

Conclusion

As shown by the ethnographic recollections of mental health professionals during the Boxing Day tsunami recovery projects, mental health interventions following the tradition of a Cartesian duality were not always compatible with how the survivors themselves have processed the tsunami. In contrast, embodiment's focus on the individual's experience – how they come to analyse and process a given incident – helped psychiatric interventions become more holistic in its efforts to identify and alleviate mental distress. By supporting and encouraging survivors to share their experiences while finding trained personnel who are capable of understanding mental pain in cross-cultural contexts, the ways in which people experience and understand phenomena are taken into account, instead of imposing solely biomedical or psychosocial perspectives onto their

accounts. The next chapter will examine how certain survivors were excluded and marginalised in the humanitarian interventions they encountered during the tsunami recovery process, and what participatory development schemes can do to remedy the status quo. Since significant personal and social elements coexist in fields such as mental wellbeing and distress, incorporating local understandings of abnormal behaviour and mental anguish is necessary. However, given participatory development's reputation as a tyrannical process, is there still some use of the concept? How can we transform the notion of participation from such perceptions towards something that genuinely supports inclusion? Through rethinking what it means to participate from a socio-political perspective, people's experiences are taken into account in places where they matter: policymaking and governance.

Chapter 3 – Rethinking 'Participation' in Development

The first two chapters discussed how certain mental health interventions in Sri Lanka following the 2004 tsunami failed to achieve their objectives. In response, this chapter will propose one possible method towards overcoming similar future predicaments. I will first examine one of the main polemics presented in development studies – the self-help paradox – which will then expand onto an attempt at answering this conundrum using participatory development. Its definitions and applications in development projects will be discussed, alongside its criticisms which have already been well documented[4]. I will then argue that by re-considering what it means to participate and to 'include' people by grounding participatory development in political engagement and raising awareness of collaborative mental health policymaking as a citizenship right, participatory development can move beyond the 'tyranny' as argued by Kothari (2001) and into something more 'inclusive' as suggested by Cornwall (2004). Using Hickey and Mohan's (2004a, 2004b, 2004c) vision towards 'relocating participation,' attempts at improving mental health facilities need to be promoted by local communities through increasing their political involvement. Put succinctly, any NGO or additional government interventions must be in line with and expand the Sri Lankan Ministry of Health's 2005-2015 Plan on Mental Health, focusing on presenting deliberative processes of creating mental health policies as a right based on citizenship. How can development agencies help the developing world improve its livelihoods? Perhaps by understanding first how these people come to understand their surroundings and individual agencies, the

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[4] Please refer to the first footnote about critics of participatory development.

importance of political engagement and the various ways in which power manifests itself, participatory development becomes a catalyst of change.

Helping Others Help Themselves: Paternalism or Altruism?

One of the challenges in development policy is the 'self-help paradox' (Ellerman 2001): how can international NGOs, outsiders to local communities, assist them in their endeavours towards self-determination without undermining their agency? In response, participatory development has been suggested as a means of overcoming paternalism in development projects. Starting with Chambers' (1981) identification of biases that have been left ignored by field workers, he proposes various methods such as rapid rural appraisal (RRA) and participatory rural appraisal (PRA). These techniques feature a wide range of activities designed to encourage participants to express their opinions and create guides on their everyday lives through methods such as roleplays, interviews, games, maps, matrices and calendars. Various communication techniques are often used because literacy levels vary greatly between different villages and families (Chambers 1981, 1994; IDS 1996). Given the role of development workers as facilitators whose aim is to evoke and 'tease out' the answers from local communities themselves, they are in theory supposed to prioritise local agency and values over their personal convictions (Mosse 2011:17). In other words, fieldworkers are 'brokers' between their employers – multilateral or national institutions and non-state actors – and the local community (Olivier de Sardan 2005:167-168). Participatory development's origins stem from an increasing recognition towards the importance of inclusion and knowledge integration. By incorporating a 'local' voice into schemes, practitioners hoped that projects would better reflect the areas in which their policies were implemented.

However, participatory development has had its share of critics, who deride the initiative as a farce. In spite of its well-founded intentions, 'participation' has become an 'empty signifier' simultaneously full and devoid of meaning, whose assumptions on developing countries entail naive portrayals of local communities (McKinnon 2007; Mohan and Stokke 2000). Participatory development projects have faced criticism due to a lack of stable theoretical grounding that guides how participation takes place (Hickey and Mohan 2004b). Given the lack of such foundations, participatory development became overly malleable to the extent of becoming the antithesis of its initial objectives, an example being the World Bank's Poverty Reduction Strategy Paper (PRSP) initiative. Despite its rhetoric about local participation, PRSP schemes became 'top-down' due to their centralised and culturally 'neutral' nature that ended up controlling, rather than supporting, local communities' autonomies (Hickey and Mohan 2004c). Power relations are created in spaces of participation, where local knowledge can be moulded accordingly to suit the needs of the development professional or village elites (Cornwall 2004:80-81; Mosse 1994, 2001). Furthermore, exclusion can also take place within cultures with little intervention by development agencies. Gender discrimination is one example, where the male chieftains in their respective communities have the utmost authority over issues related to every villager. This places women at a disadvantage when expressing their opinions (Blanchet 2001:640). Participation does take place, but its desired outcomes remain elusive due to failing to incorporate various structural factors or by treating them as static concepts.

Therefore, if development practitioners were to seek local perspectives and knowledge on a given topic, getting to know how people experience and process said

topic is important. For a domain such as mental distress that has a significant personal component associated to it, 'local' and 'personal' perspectives play an important role in outsiders determining their course of action (Campbell and Burgess 2012; Miller 1999). Kleinman (1988) pointed out the non-responsiveness of psychiatrists in regards to symptoms of clinical depression expressed by patients in developing countries; Richter (2004:446) takes a more self-critical stance by arguing that development practitioners have hitherto avoided targeting and treating mental anguish over problems that she defines to be 'easier,' such as supplying lodging, garments and foodstuff. Mills (2014) has critiqued the work of BasicNeeds, a South Asia-based NGO; one of their initiatives at raising awareness of mental health in India involved distributing pictures of people with potential 'symptoms' of mental anguish. However, the images were not formulated in consultation with local communities, resulting in BasicNeeds deciding what is 'normal' and 'abnormal' on their own, while they considered their work as that of 'civilising' Indian society (Mills 2014:63, 65-68). Consequently, such practices have reproduced the 'double-edged sword' outcome from unilaterally pathologizing mental anguish that was discussed in Chapter 2. While creating initiatives to incorporate communities' viewpoints is important, it is equally essential to be aware of the power relations between not only the development practitioners and the communities, but also within the community as well.

Does A Pill A Day Keep the Madness Away? Mental Health in Sri Lanka

Sri Lankans are open to using both traditional and Western healing methods, often with specific guidelines on when to consult a certain branch of medicine. As discussed in Chapter 1, certain Tamil Sri Lankans opted to consult multiple goddesses and deities,

particularly in the wake of the tsunami as they were expressing anger towards their Tamil goddesses for not having protected their families and homes (Lawrence 2000, 2010). Similarly, health pluralism usually occurs in communities where people prefer its focus on incorporating multiple treatment methods to establish 'completeness' in examining the body, alternating between Western treatments and locally cultivated solutions as seen fit (Tribe 2007). For instance, many rural Sri Lankans consult Ayurvedic medicine and religion in regards to physical and mental distress respectively, mixing the two under certain instances (Lawrence 2010; Tribe 2007). Ayurvedic medicine is similar to other examples of 'holistic medicine' that consider the body as a sum of its organs, minds, environments and systems – in other words, the body as a whole (National Institutes of Health 2013; Weston 1992:75-76). Its approach focuses on maintaining equilibrium between the body, mind and spirit through herbal solutions designed to improve people's vitality and provide pain relief (National Institutes of Health 2013). This is in contrast to the materialist, biomedicine-centric approach of Western medicine cultivated by the 'clinical gaze' that separates the disease and its signs from the sufferer (Aho 2008; Foucault 1963; Leder 1992). Health pluralism is an ongoing practice in Sri Lanka with which its practitioners are satisfied; Western medicine's 'absolute' values are likely to be questioned by those who consult multiple sources of medical advice.

After the tsunami, many international NGOs arrived with preconceived notions on Sri Lankan perspectives on mental health, as illustrated in Chapter 1. An American therapist who spent time in Sri Lanka stated that a lack of proficiency in Sinhala and Tamil or knowledge of Sri Lankan cultural attitudes served as an advantage: 'One of the requirements of disaster trauma counsel[l]ing is to be non-political and non-

denominational. We must not be influenced by religion, ethnicity or political affiliation (Watters 2010:75).' Given that Western mental health professionals assumed they were dispatched to conduct the psychological equivalent of 'applying a compress to someone's injured head,' many dismissed the importance of socio-cultural factors and focused on facilitating rapid mental health interventions (Watters 2010:75). This is because Western mental health professionals are, generally speaking, taught to remain impartial, apolitical and adopt a culturally 'neutral' stance. One of the most frequently utilised therapy techniques by Western psychiatrists and psychologists is titled 'critical incident debriefing,' which entails a verbal, immediate recollection of the traumatic incident by the survivor (Mitchell n.d.). As the mind is a distinct entity from the body according to the Cartesian duality, many Western mental health professionals thought focusing solely on psychosomatic or psychological symptoms was sufficient to relieve people of their mental 'illnesses' (Leder 1984; Watters 2010). Furthermore, a simplified but parsimonious message was more likely to gain donor support (Campbell and Burgess 2012:381). Therefore, aid agencies assumed that other non-Western cultures would behave in a similar manner to Western societies, further reinforcing the universalist assumptions in Western psychiatry and development practitioners' confidence in its techniques.

However, ethnographic evidence gathered by mental health professionals from a Sri Lankan cultural background suggested otherwise. The one-sided, homogenous and non-cultural approach adopted by mental health professionals exacerbated what was already a rushed humanitarian intervention scheme full of miscommunications and lacking in co-operation (Stirrat 2006). As cautioned by Bruner (1986) when discussing

the complications surrounding the anthropology of experience, the tsunami survivors' verbal expressions were assumed to completely represent their experiences. However, certain tsunami survivors did not express grief openly, preferring instead to first internally process the source of their grief, seek guidance from deities and then grieve in public (Fernando 2005, Lawrence 2010). Consequently, pathologising distress as an 'illness' that could be cured using universalist assumptions founded from Western psychiatry resulted in relief programmes that did not consider the survivors' socio-cultural backgrounds, two of which were described by Wickramage (2006:168):

> In Kalmuani in the Eastern province, a foreign group offered sessions that integrated drama and music therapy as a means of 'psychosocial release'. This psychosocial drama 'troupe', conducted a once-only psychosocial workshop with the children and young people of the affected communities (predominantly Muslim), involving expressive Western dance and song, in an area near a mosque. The vehement response by some community leaders and Imams of the local area to government authorities came swiftly.
>
> (…)
>
> A headline in one island newspaper many months after the Tsunami read; '17 Japanese experts arrive to undertake psychosocial activities for Tsunami victims', and written somewhere near the end of the article the comment 'bi-lingual interpreters needed urgently'.

The hastiness shown by these humanitarian and development organisations led to ineffective policies in Sri Lankan communities, due to the short-term nature of their interventions that also happened to disrespect their audiences' values. If they had taken some time to negotiate with local and international NGOs to understand existing socio-cultural attitudes instead of hastily pursuing interventions, perhaps more thoughtful, effective and well-executed mental health plans would have been implemented.

As discussed in Chapter 2, this is where incorporating socio-cultural aspects into examining the mentally anguished can contribute positively, one example being emic-etic mental health frameworks. For example, the Armenian earthquake of 1988 was the first time humanitarian psychiatry took place, according to Fassin and Rechtman (2009). The motivations behind humanitarian psychiatry were mostly based on Armenian psychiatrists' longing to return to their homeland to assist their distressed compatriots; thus their actions were justified by 'humanitarian reason' (Fassin and Rechtman 2009:166-167). Having mental health professionals who understand the local socio-cultural setting can help overcome the expression-experience impasse, as demonstrated by the Armenian psychiatrists who returned to their home country in their compatriot's hour of need. Their Sri Lankan counterparts were not only able to communicate with fellow aid workers in a 'technical' language of local people's needs, but also capable of empathising and relating to their concerns (Fernando 2009; Ganesan 2006, 2011; Gilbert 2005). As warned by Bruner (1986), the anthropology of experience has often been dismissed as hermeneutics, since people frequently communicate their feelings and experiences using verbal or body language. However, by understanding how local communities operate, it is possible that these expressions are interpreted as experiences in their entirety. In addition, culturally bound syndromes and non-communicable phenomena can also be better understood through culturally informed mental health personnel.

Tsunami survivors who undertook mental health policies that were deliberative and inclusive thought their time spent was useful in relieving mental anguish. In describing the role of the cultural psychiatrist, Fernando (2004:109, 2012) argues that

combining the emic – local religious and social values – and the etic – Western psychiatric and psychosocial methods – together is the ideal method for mental health interventions in developing countries. Instead of deploying impartial, single debriefing sessions as proposed by American therapists Watters (2010) interviewed, culturally informed continuous assessments with empathy and the ability to listen were more likely to be effective in determining the causes of mental anguish. The tsunami survivors considered the process as one about building personal ties and 'getting to know [them]' instead of a psychiatric version of a full body examination: invasive, impersonal and often ineffective (Fernando 2009:109). This has parallels with Cornwall's (2004:87) exposition of 'invited spaces' that suggests a shift towards more inclusive participatory projects, where participants are able to set their own parameters and subsequently have greater autonomy in expressing their thoughts and experiences. Fernando (2009) enquired with a local Catholic parish priest in selecting group therapy participants in Batticaloa. When the participants were informed of Fernando's (2009) Sinhalese roots and project aims, they felt privileged and comfortable to share their recollections with someone who understood their tribulations and socio-cultural values. Whenever labels and definitions are established, they must be done so in a collaborative manner where both development practitioners and local communities are equally aware of the implications of their actions and accept them.

In particular, group therapy sessions that fostered a sense of belonging and welcoming sentiments were likely to encourage participants to discuss their feelings and experiences more openly. The benefits of group-based psychosocial treatment have been documented in other instances: Johnstone (2007; cited in Fernando 2009:5) observed that

relief efforts after Hurricane Katrina involved group therapy sessions, which strengthened bonds between relief work volunteers and the survivors, while enhancing ties within each group as well. Fernando (2009) discusses the benefits of group work by citing her experiences working with female Sri Lankan survivors of the tsunami:

> In the final session, I asked members about their group time together and what it meant, including what lessons members had learned about themselves, from each other, and from the group as a whole. … When asked how it felt to help one another, they reported that it felt good, and that they never thought they had it in them to help another because of the assumption that they had nothing to offer to others. They believed they were too focused on themselves and their suffering (Fernando 2009:11).

Considering that many of the group therapy participants had lost family members, through their peers they were able to devise a 'new' kin group. Furthermore, this particular group therapy session encouraged people to express how they experienced the tsunami through their emotions and speech, thus reaffirming Jackson's (1998, 2005) definition of life as a process through which people guide themselves. As Gilbert (2005) argues, the most important thing a development practitioner must have is empathy and the ability to listen to different perspectives. Despite their material losses, by evoking a sense of collectivism ingrained in various Sri Lankan customs as a means to support each other in their times of need, the survivors left the group sessions feeling much more stable. They found one of many new purposes in their lives: listening to fellow tsunami survivors' concerns, while having their own grievances heard. It is not my intention to present group therapy as a panacea, but rather a mental health policy model that can be effective subject to certain conditions being met.

The Bigger Picture: Incorporating 'Inclusiveness' into Reforms

In light of the tsunami and its aftermath, the Sri Lankan government in 2005 announced a ten-year plan dedicated towards improving access to mental health facilities and training more professionals. Given the lack of trained psychiatrists and psychologists in areas heavily affected by the tsunami, the government decided to take action by establishing more clinics and training more mental health personnel, ranging from counsellors to psychiatrists (Fernando 2005; Ganesan 2006, 2011). Combining the decades of trauma and anguish suffered from the Sinhala-Tamil ethnic conflict and the tsunami, the Sri Lankan Ministry of Health estimated that up to 2% of the population suffered from some form of behavioural disorder (Sri Lankan Ministry of Health 2005:1). In response, the Ministry's 2005-2015 Mental Health Plan announced broad reforms such as having at least two counsellors for all health districts, refurbishing existing mental health facilities and establishing a National Institute of Mental Health to train mental health professionals and conduct research (Sri Lankan Ministry of Health 2005; WHO 2013). Having witnessed international NGOs' psychosocial interventions and the consequences of being inadequately prepared for addressing people's mental anguish after natural or manmade disasters, the Sri Lankan government announced a framework towards formalising and expanding mental health treatments across the country.

However, whether such reforms have been focusing on simply increasing facilities and the number of trained psychiatric professionals, or if they involve genuine attempts at incorporating people's experiences of mental distress remains to be seen. A WHO (2013:76) report claims that the Ministry of Health's 2005-2015 Plan focuses on decentralised community-based care systems. It also illustrates increasing access to

mental health assistance across the country from 2004 to 2013 with additional intermediate care units, psychiatry inpatient units and community outreach clinics being built through the 2005-2015 Plan; districts that were affected the most from the tsunami were some of the first ones to receive such comprehensive coverage (WHO 2013:77). Despite such publications announcing a successful transformation of mental health policy in Sri Lanka, neither the Ministry of Health's (2005) plan nor the WHO (2013) report discuss in detail how community counselling takes place. Although the plan mentions follow-up treatments to monitor people's mental stability over medium/long-term periods and district-level mental health plans being formulated in conjunction with the national government (Sri Lankan Ministry of Health 2005:4), whether the counsellors are qualified psychologists, psychiatrists or what forms of therapeutic methods they will use are left undiscussed. Furthermore, while the report mentions increased regulation of psychotropic drugs, it does not provide a mechanism for such measures (Sri Lankan Ministry of Health 2005:2). Despite increasing physical and manpower capacities of mental health facilities, whether the interventions themselves will be inclusive and focus on the patient's socio-cultural as well as physical body remains unanswered.

The suspicions raised in the previous paragraph stem from a phenomenon not exclusive to Sri Lanka: policymakers' detached lives in relation to the wider community. Argenti-Pillen's (2003a) examination of the 'Cinnamon Gardens,' a network of international humanitarian and aid NGOs and executives in Sri Lanka, showed several contentious aspects of their behaviour. Sinhala is an expressive language with multiple ways to describe ideas that are expressed using one word in English. However, most of the translations of Western medical concepts such as 'occupational therapy' and 'pity'

stem from 'Colombo-style Sinhala,' which is almost exclusively spoken by the Sri Lankan elite (Argenti-Pillen 2003a:194-195). Considering that the most of the severely tsunami-affected areas had a Tamil majority whose mother tongue is not Sinhala, primary religion is not Buddhist and consults multiple sources of medical advice, culturally inappropriate translations of various mental distresses were not uncommon (Argenti-Pillen 2003a; Kuhn 2010:44-45). Argenti-Pillen's (2003a) observations largely confirm Harper's (2011) examination of their Nepalese counterparts who live in gated communities, communicate almost exclusively in English and are detached from Nepalese everyday life. When health personnel are detached from their clients' lives and are unable to empathise and understand their situations, it is somewhat unsurprising that they have been unable to achieve their objectives regarding something as subjective as mental health. International health professionals' inability to communicate with their neighbours, as noted above, is detrimental towards creating effective mental health policies.

Furthermore, despite the 2005-2015 Mental Health Plan showing potential towards reforms, the Sri Lankan government's commitment towards future plans remains doubtful. As Higginbotham (1984) states, 'national will' towards mental health funding remains low not only among governments, but also private medical firms that operate on a national level. This has been argued for by the WHO (2010), whose report revealed that 25% and 40% of all surveyed countries respectively have no legislative measures or policies to address the increasing incidence of mental illnesses; consequently, an argument based on 'political will' can be made (WHO 2010). In 2008, the Sri Lankan government allocated 1.32% of its national health budget towards three mental hospitals;

considering that up to 3% of the Sri Lankan population were estimated to be suffering some form of mental anguish, there is a discrepancy in funding for mental health (Kitsiri 2009:23; WHO 2008: cited in Kitsiri 2009:9). In response, Reich (1994) proposes examining the political feasibility of public health projects, as this would enable political cost/benefit analyses to be conducted. Such calculations explain how politicians are incentivised to prioritise certain policies over others; in other words, mere 'political will' cannot persuade others to change their opinions on mental health, but political incentives can (Reich 1994). In any case, what remains clear is a comparatively smaller funding allocation towards mental health in Sri Lanka compared to other maladies, raising questions on the feasibility of maintaining the momentum gathered from the 2005-2015 Mental Health Plan.

As a result, participatory development projects must be underpinned by political reforms and promotions of people's rights through citizenship, so that local communities act on their own volition towards policy reforms. Hickey and Mohan (2004a, 2004b, 2004c) propose a 'radical politics of development' that will modify participation from its tyrannical ways as argued by Kothari (2001). Participation must be perceived as a part of a citizen's rights, followed by incorporating participatory measures into broader political reform programmes that aim to re-engage 'the technocratic expression of participation with one of its more theoretical, political and radical antecedents' (Hickey and Mohan 2005:245). Through integrating participation with citizenship, it becomes redefined as a 'right' to which everyone is entitled, serving as an example of individual agency in the political realm (Lister 1998:228, cited in Gaventa 2004:29). Applying this to a mental health context would imply that access to deliberative, non-paternalistic mental

healthcare must be defined as a 'right' that people are able to request to the government based on their citizenship and must be lobbied for accordingly. This is undertaken by external non-state actors or communities mobilising themselves on their own to engage with politicians and provide incentives for policymakers to take action (Hickey and Mohan 2004b, 2004c; Reich 1994). Put succinctly, mental health policies must be 'anchored' by overarching reforms taking place, which are being promulgated by local communities through collaborative, deliberative processes towards political change. I am not suggesting that non-state actor presence and supporting the mobilisation of local communities in political engagement are panaceas, but rather that they are suitable starting points towards instigating inclusive participatory development.

However, such conceptualisations of people's experiences need substantiated action; this is where non-state actors can contribute towards ensuring dialogue between communities and governments remain inclusive for local citizens to express their views. Campbell and Burgess (2012) emphasise the need for establishing a mutual understanding of mental health between development and mental health practitioners and local communities. In spite of such inclusive rhetoric, they however do not propose any specific examples through which mental health projects can avoid reproducing past failures. Similarly, Fernando (2012) recommends initiatives such as creating the 'language' of GMH beyond its usual rhetoric of 'scaling-up' policies and linking psychiatric research with aid donor interests, the article also does not explain how her suggestions can be implemented effectively. While NGOs such as BasicNeeds have engaged with local communities towards raising awareness of mental illnesses, the message they transmit has had little consultation from local communities. Furthermore, the messages are often

left unquestioned on the grounds of BasicNeeds' knowledge coming from Western psychiatry, which is deemed to be modern and therefore superior (Mills 2014:60-69). Although no universally applicable examples of models to balance state and non-state actors currently exist, when its preconditions such as an equilibrium of power and voice in the space of participation are attained, they can lead to benefits such as greater political representation, starting new inter-class and institutional ties and creating 'town hall' sessions for local villagers to hold politicians accountable (Gaventa 2004; Williams 2004:99-100). Provided NGOs and local community leaders can maintain the delicate balance between inclusive and closed spaces for discussion, participatory development has the potential to incorporate local insights in places where they matter, such as policymaking.

Finally, participatory practices claiming to be inclusive must be capable of questioning its methods and assumptions. Self-reflexivity, like many other social sciences concepts, is hard to define specifically. Generally speaking, it involves 'a scientific inquiry also being the subjects who carry out the inquiry' (Flanagan 1981:375). This is similar to what Bourdieu (2003:282) proposes as 'participant objectivation,' which takes into account 'the social conditions of the production of these pre-constructions and of the social agents who produce them.' Self-reflexive practices should be undertaken by all development practitioners and academics, as 'the capacity to listen to the person in need in his/her full social, economic, and political context' provides the foundations for 'internal observers' Gilbert (2005:64). The internal observer is able to distinguish where his/her 'biases' affect what kind of knowledge – official or informal – to utilise in their interactions with fellow development practitioners and local communities, paying

attention in particular to how they express experiences through speech or emotions. This is achieved through considering – or 'listening to' – what kinds of knowledge are being transmitted by the development agency to its employees, after which the employees themselves decide a suitable course of action (Gilbert 2005; Tamas 2007). When physical sites of participation are established, policymakers must consider how the *social* spaces of participation operate. After all, social spaces are never 'neutral' and this point must be constantly reminded to Western or local bureaucratic organisations and local communities (Cornwall 2004; Gaventa 2004:34-35; Williams 2004). While development practitioners cannot 'bracket' – the act of suspending judgement stemming from a certain branch of thinking (Desjarlais and Throop 2011) – their socio-cultural and educational influences completely, they can at least acknowledge their influences and take heed whenever necessary.

Conclusion

Through reconsidering participatory development from a citizenship-based perspective and applying it to mental health interventions, the importance of people's experiences is emphasised. When people who were previously excluded are brought into a space of participation and inclusion, vested interests of development practitioners or village elites could play a role. However, through focusing on group therapy, empathy and common socio-cultural background, participatory development can take a different course. A balanced emic-etic framework for not just mental health, but also development policy in general harnesses the best of both worlds: local perspectives that illustrate historically and currently significant factors in everyday life are combined with the material and economic expertise of development practitioners. By considering people's

recollections as something beyond 'symptoms' of a phenomena but as phenomena themselves, what Cornwall (2004) proposes to be an 'inclusive' space is created, as their recollections are not treated paternalistically, but on equal footing as peers helping one another out. Such ideas have already been covered by Campbell and Burgess (2012) and Fernando (2012); however, given participatory development's reputation as a mere façade of inclusiveness, they must be substantiated by self-reflexive behaviour, while promoting political engagement as a starting point to implement inclusive, effective mental health policies and raise awareness of the issues. Local-level interventions must be integrated into wider socio-political reforms through encouraging discussions and collaborations. In particular, such processes can pave the way towards institutions that measure the accountability and transparency of development practitioners, focusing in particular on conceptualising and promoting non-paternalistic mental health treatment as a right for all Sri Lankan citizens.

Conclusion

Mental health interventions in developing countries, despite well-intended actions of Western development agencies, have failed to achieve their objective of completely reducing short-run mental anguish in Sri Lanka after the 2004 tsunami. A poorly coordinated and overly competitive international non-government organisation (NGO) sector led to a lack of specialisation and identifying local material and medical needs. While projects involving material assistance involved local input, certain mental health policies involved no consultation, on the grounds of universalist assumptions regarding mental suffering. Critiques regarding the seemingly apolitical nature of development policies that in fact often espouse vested interests are not uncommon. I have shown in Chapters 1 and 2 that mental health policies in an aid & development context are no exceptions to the generalisation stated above; Western psychiatry's grounds for legitimacy stems from a materialist approach towards understanding human suffering, influenced by the mind-body Cartesian duality. Despite the fact that many have critiqued the arbitrary nature of categorising the mind and the body as such – two distinct, disjoint entities – it continues to be influential and widely used in psychiatry and biomedical practice. In 2004, Sri Lanka was struck by two tsunamis: one on Boxing Day and another one involving misguided, culturally insensitive and paternalistic mental health policies.

Chapter 2 was an exercise in 'blurring' the Cartesian duality to highlight how bodies are not mere physical subjects, but also socio-political entities capable of embodying and exerting agency. The ambivalent nature of 'mental health' also remains difficult to resolve; the notion of embodiment, stemming from phenomenology, offers some alternatives. Despite attempts to move beyond the Cartesian mind-body duality, the

differentiation made between 'suffering' and 'illness' and making a case for including the 'mind' into medical analysis only reinforces the disjointed nature of understanding human beings (Leder 1984, 1992; Scheper-Hughes and Lock 1987). Instead, by examining the human body as the 'lived-body' – a sum of its senses, movements, experiences and behavioural patterns – a complete picture of the patient's life is created beyond their bodily organs (Leder 1992:33). Emotions serve as an example of the mind-body duality being blurred, where expressions of anxiety or anger are associated with faster breaths being taken, while calmness is often conveyed through a steady pace (Lyon 1997). Moving beyond Foucault's (1963) clinical gaze to treat human anguish as it is, instead of relying on the Cartesian duality, is a step that remains to be taken by mental health professionals. Critiqued by many but still utilised by many others, the mind-body distinction and its descendent – Western psychiatry – leaves more questions than answers when attempting to explain 'mental' health.

In Chapter 3, I highlighted community-based group therapy as a means towards breaking through the so-called 'tyranny' of participatory development, but I also cautioned its usage in an apolitical, culturally 'neutral' stance. The problems identified with the Cartesian duality in Chapter 2 resemble the issues participatory development faces: despite its intentions towards a more inclusive, collaborative development policymaking, it has been manipulated, unwittingly or wittingly, by development agencies under an 'apolitical, technical' veneer. There has already been rhetoric that proposes for more 'inclusive' participatory development processes, but with little applicability and concrete examples (Chambers 1994; Cornwall 2004; Hickey and Mohan 2004c). Consequently, collaborative, non-paternalistic mental health facilities must be

treated as a right founded on citizenship. In other words, people must campaign towards

inclusive mental health policies as a universal right that protects people's wellbeing,

eventually leading to institutions that monitor state and non-state actors' actions for the

local community. Citizens then are inspired to take action, promoting access to mental

health facilities as a citizenship right. Therefore, rhetoric must be affixed to and run

concurrently alongside overarching development policy and government reforms, so that

politicians are incentivised and held accountable (Gaventa 2004; Hickey and Mohan

2004a, 2004c). Participatory development, despite the amount of criticism it has endured,

still has some useful features. Its aims towards incorporating local perspectives can be

achieved by fostering an environment where people's experiences are valued and

implemented, through amalgamating them into broader political movements as a starting

point.

Merging the three strands of participatory development, phenomenologically-

informed anthropology and psychiatry creates a useful framework in examining mental

health policies in developing countries. Given the anthropology of experience and

embodiment's focus on understanding the world as it is without predispositions,

psychiatry's examinations of the human mind and participatory development's intentions

towards inclusive, deliberative development projects, the three disciplines cover each

other's limitations while providing a different approach towards understanding an

increasingly pertinent topic: mental health in developing countries. The subjective nature

of mental illness and suffering suggests embodiment is well-suited towards explaining

why past and present mental health policies based on a biomedical-centric understanding

of human suffering failed to achieve their objectives (Aho 2008; Leder 1984; Fernando

2005, 2009; Ganesan 2006, 2011). There is more to human anguish than a pill – such initiatives represent misguided applications of reductionism that omit socio-cultural and personal implications (Li 2007; Mills 2014). Through examining mental health policies in developing countries using lenses such as embodiment and community-based political reforms, focusing in particular on people's experiences and rights from citizenship, participatory development can take a different meaning. In particular, initiatives to create a space of dialogue – one which is often non-neutral (Cornwall 2004) – that is more 'inclusive' can take a different meaning by encouraging people to express their experiences in a culturally appropriate manner so that their voices are heard through political engagement.

Future Avenues of Research

New areas of research could involve devising a substantiative framework to conduct mental health policies through an experiential, embodied and rights-based approach that integrates local perspectives towards mental distress with Western psychiatric methods in developing countries. Due to the interconnected nature between emotions and mental distress, examining ways to incorporate emotional experiences more effectively through participatory development or other methods could help address mental health issues (Lyon and Barbalet 1994; Lyon 1997). However, fieldwork is needed to find specific examples of treating mental health as a right through 'participatory citizenship.' While I have suggested that mental health policy should stem from local political engagement and mobilising villagers to raise awareness of mental health by using Hickey and Mohan's (2004a, 2004b, 2004c, 2005) framework, Gaventa (2004) points out that conditions for effective participatory governance vary for all locations and

situations. In this thesis I interpreted group therapy sessions in Sri Lanka using the concept of embodiment and suggested them as an example of inclusive and culturally sensitive mental health treatment. However, empirical evidence gathered from fieldwork is needed to better explain how group-based treatments evoking emotions can help alleviate mental anguish and how such processes can take place under the auspices of citizenship and rights.

Another area to examine is the relationship between pharmaceutical companies and mental health professionals in developing countries. I hinted at some existing correlations in the Introduction and Chapter 2 such as the question of why psychiatrists and psychiatry-influenced mental health interventions are still preferred by development and aid agencies, the increasing usage of antidepressants in India using Mills (2014) and Ecks and Basu's (2009) case studies and the rise of MGMH. However, explicit casual relations are yet to be established. As mental health in developing countries starts to gain more attention, signs – be they subversive or explicit – of pharmaceutical companies aiming to prioritise profit over people's wellbeing in developing countries must be enquired upon promptly. Mills' (2014) approach grounded on colonial discourse explains the one-sided nature of mental health interventions conducted by India-based NGOs effectively, but it could equally be considered as an overly deterministic reading of the situation. One possible conceptual framework that could be used is to examine developing countries' access to psychotropic medication from a security background – in other words, the securitisation of pharmaceuticals in developing countries.

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