# DECOLONIZATION THROUGH MADNESS: A CRITICAL ANALYSIS OF THE IMPLICATIONS OF GLOBAL MENTAL HEALTH IN THE CONTEXT OF BANGLADESH

by

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# Abstract

The global mental health movement has given rise to a new discourse on the implication of the use of psychiatric-biomedical categories of disorder to standardize a global approach to mental health and illness. The aim of this research is to understand how the western biomedical categories of disorders are enforcing the erasure of local understanding of health, illness, and suffering in Bangladesh. Through the exploration of madness as a method of decolonizing ideas of mental disorder in Bangladeshi research, the research sets up new ways of integrating anti-colonial and collaborative approaches in studying illness and affliction in Bangladesh.

# LIST OF ABBREVIATIONS USED

| | |
|---|---|
| WHO | World Health Organization |
| GMHM | Global Mental Health Movement |
| GMH | Global Mental Health |
| LMIC | Lower and Middle Income Countries |
| MNS | Mental, Neurological and Substance |
| SDGs | Sustainable Development Goals |
| DSM | Diagnostic and Statistical Manual for Mental Disorders |
| MDD | Manic-Depressive-Disorder |
| DASS-21 | Depression, Anxiety, and Stress Scale, 21 |
| DALYs | Disability-Adjusted Life Years |
| ICD | International Classification of Diseases |
| CAM | Complementary and Alternative Medicine |
| SRQ | Self Reporting Questionnaire |
| RQC | Reporting Questionnaire for Children |

# 1

# Introduction

Discussions around mental health have become part and parcel of our everyday lives. According to the WHO, the alarming increase in mental disorders on a global scale requires country-specific actions (World Health Organization [WHO], 2020). The numbers cited by WHO and supporters of the Global Mental Health (GMHM) movement have created a notion of a crisis of an epidemic level (Applbaum, 2015). The GMHM has launched a worldwide campaign to address the disparities in care for mental health around the world, with a particular focus on lower and middle-income countries (Applbaum, 2015; Kohrt & Griffith, 2015; Beneduce, 2019). Scholars of both cultural psychology and medical anthropology, as well as social science in general, have wondered whether the global scale initiatives will produce hegemonic practices that do not consider the diverse experiences related to mental health (Summerfield, 2012; Kohrt & Griffith, 2015). GMHM has reintroduced debates around the politics of diagnosis, hegemonic and counter-hegemonic knowledge, bureaucratic violence, and the nature of mental health itself (Beneduce, 2019; Kohrt & Griffith, 2015). The answers to these questions should not be viewed just through the western biomedical lens. Knowledge about local epistemologies of mental illness and healing practices should be considered when creating practices and policies regarding mental health, especially in the context of the Global South. This MA thesis aims to question the translatability and limitations of explanatory models offered by biomedical categorizations of global 'mental health' in the

local contexts of Bangladesh. I argue that here is a lack of flexibility and acknowledgement of local epistemologies within the standardized categories of global mental health. I chose to explore the complex and changing landscape of madness in Bangladesh through the lens of decolonization to showcase the frigidity and forced boundaries of 'mental health' categories that do not fit the epistemology of *Paglami* (madness) and mental illness of Bangladesh.

One of the key factors throughout this thesis has been to explore the gaps left by the western discourses and methods in understanding madness and mental illness in Bangladesh (Callan, 2012; Wilce, 2008) by the examination of the complexities and politics of applying one dominant form of knowledge embedded and created in specific historical and cultural contexts into another (Noble, 2007) through an anti-colonial approach. My argument is tied to the critique of the global mental health movement that suggests a universal crisis resolution and treatment practices in response to the rising cases of mental illness worldwide (Beneduce, 2019). The notion of a 'global mental health crisis' glosses over context and evidence-based data, which can have the ability to produce hegemonic knowledge systems (Rose, 2019; Applbaum, 2015). To counter the hegemony, this research will focus on a deep and comprehensive understanding of how ideas and practices related to the very notion of "mental health" and illness are created, maintained, contested, and negotiated on the global scene. The thesis will assess how categories of mental illness in global mental health (GMH) become dominant forms of knowledge within GMH interventions that promote evidence-based localized interventions based on a standardized medical model. In order to answer that, we first need to understand what the dominant mental health categories consist of and how they

are related to local categories of illness models. It is essential to locate and explain the source of knowledge hierarchy in mental health research to better understand how it affects the local etiologies and practices related to “mental health.” Although it is important to bear in mind that what constitutes “mental health” or, more specifically, “global mental health”(GMH) is not static. The underlying assumptions have led anthropologists and other scholars (Whitley, 2015) to delve deeper into the genealogy of GMH (Lovell et al., 2019). One of the key features involves the circulation of knowledge regarding “mental health” from the center formed in the Global North to its application and experimentation in the primarily poorer regions of the Global South (Lovell et al., 2019, p.520). Even though there are questions regarding the validity of mental health practices in the west (Heaton, 2013; Horowitz, 2011; Ludtke, 2008; Summerfield, 2012), the application of western categories and instruments in psychiatric research on non-western populations rose during the 1990s, especially in the areas of refugee studies (Summerfield, 2012, p.5; Edington, 2021). The use of western categorization in community mental health services promoted by the WHO inspired narrow biomedical views of the patients’ everyday lives and realities, resulting in inaccurate translation of people’s worldviews and collapsing the community services into prescription pills (Summerfield, 2012, p.4). The preference for western “mental health” categories is shaping the public health discourse in Bangladesh through the introduction of GMH practices by organizations like WHO which has been instrumental in influencing the Bangladesh Mental Health Act 2018. The WHO reports on the mental health status and services in Bangladesh, such as the *Bangladesh WHO Special Initiative for Mental Health Situational Assessment (2020)* and even the Mental Health Act (2018) of

Bangladesh, which was drafted in collaboration with WHO and Bangladesh Association of Psychiatrists (Karim and Shaikh, 2021; Karim et al., 2006), all encourage the uses of terminologies like “mental health” and “mental illness” instead of local terminologies like *Pagol* (mad) or Paglami (madness), the latter ofwhich are heavily used by Bangladeshis. Paglami is a Bangla term that refers to a broad category of meaning that includes going mad, madness, and mental illness. The term “Paglami” can also resonate with resistance, political movement, rural and urban sentimentalities, religiosity and spirituality, excessive emotions, and love (Bhattacharyya, 1983; Callan, 2012; Sur & Sen, 2020; Wilce, 2008). I believe the exploration of the discourse of Paglami and how Paglami differs from notions of illness and disorder can help to address the limitations of biomedical categories of “mental health.” It is imperative to address the limitations of western categories, as Bhattacharyya (1983) aptly explains by noting that social aspects are vital in the studies of the Bengali mental health care system and that these elements may or may not seem relevant in the western discourse of mental health or mental health care systems (see also Koen 2013; Ludtke 2008). Young (1976) articulated how western biomedical practices create fragmented notions of how people in non-western countries perceive illness and diseases. Western paradigms judge treatments and explanatory models of illness based on their efficacy and cannot tolerate the existence of any other type of explanatory models that fail to uphold the same values of efficiency and effectiveness. (Young, 1976; see also Tuhwai Smith 2021) and a way of establishing them as the most efficient treatment available in the market.

I do not use Paglami and madness interchangeably here, but there are similarities between both categories, such as their flexibility and broadness as an explanatory model

in contrast to mental illness. Therefore, in this thesis, I will refrain from using the term "mental health" unless I am critically assessing it. But the categories differ on the ground in that madness in itself is a western category with a deep connection to psychiatric models (Pinto, 2020). I have chosen anti-colonial theory to support my theoretical argument. Anti-colonialism is seen as a continuous process of challenging colonial and neo-colonial legacies, relations and power dynamics, and this framework perceives colonialism as a continuous and perpetual phenomenon which is deeply implanted in our everyday lives (Thambinathan & Kinsella, 2021; Dei & Lordan, 2016; Edington, 2021). The colonial legacy had a significant impact on shaping peoples' perspectives and practices regarding madness and experiences of illness in Bangladesh (Wilce, 2008), and there is a lack of research exploring the continuous implications of colonialism through the reintroduction of global biomedical categories in mental health in Bangladesh. I argue that one of the ways to decolonize GMH approaches in Bangladesh is by exploring the discourse of what is referred to as Paglami in Bangladesh. Scholars like Gomory et al. (2013) and Pinto (2020) argue that the ambiguous and mysterious nature of madness, or simply the lack of a definition for madness, is the key to preserving a non-biomedical and non-reductionist approach to understanding how madness or illness can be experienced (Gomory et al., 2013; Pinto, 2020).

## 1.1 Mental Health in Bangladesh

As a medically pluralistic society, mental health services in Bangladesh are provided through both biomedical and non-biomedical practitioners (Callan, 2012).

Patients often choose service providers based on availability and accessibility (Nuri et al., 2018). Apart from private practitioners, hospital personnel, and psychiatrists, patients and their families avail services of local/folk healers. Folk healers in Bangladesh often borrow and adapt from biomedical explanatory models and local healing techniques. "Traditional" healing and curing practices employed by healers in Bangladesh can be divided into Islamic orthodox exorcism and Kabiraji practices (Callan, 2012; Mukharji, 2014). Even with the dominant presence of western biomedicine, the folk and local healing practices have not subsided due to the resilience, versatility, adaptability, and borrowing of biomedical models by local healers (Callan, 2012). Yet we do not know whether practitioners of western psychiatry in Bangladesh incorporate alternative and indigenous healing techniques in their treatments. Colonialism itself and the colonial legacy of psychiatry, as an arm of biomedicine, have shaped how the relationship between the mind and body has been reframed and the contortion, erasure and transformation of local knowledge globally in a multiplicity of contexts through time and space (Dirks, 1997; Edington 2021; Ernst, 2010; Grønseth, 2001; Ludtke 2008; Heaton 2013; King 2002; Lane, 1999; Moran-Thomas 2013; Waldron 2010; Waldram 2000). In Bangladesh, the imposition of a hegemonic western healing system onto a distinctly diverse culture has raptured the fabric of the colonized population and their connection to their knowledge systems. Although it did not result in the complete erasure of local practices, instead, the local practices adapted and thrived alongside the imposed western systems of (Mukharji, 2014; Callan, 2012; Addlakha, 2010; Basu, 2005). However, there is a knowledge gap regarding the history and progression of local knowledge in mainstream consciousness. Most of our research regarding mental health in the Global

South and Bangladesh has been done from a western gaze (Hasan et al., 2021; Radford, 2005; Basu, 2005). There is a need for decolonization in studying the role of psychiatry in the Global South through the exploration of history and culture to counteract the amnesia we are suffering from the damage done to Indian psychiatric practices (Basu, 2005, p.129). The colonial aspects of psychiatry have created a sense of insecurity and awkwardness among Bangladesh's psychiatrists and mental health professionals. The knowledge gap is caused by the lack of understanding about the local practices and the prejudice created based on colonial hegemony, and most doctors in Bangladesh practicing psychiatry are resistant and dismissive of the potential of other healing methods which does not subscribe to the positivist and reductionist applications of modern psychology (Wilce, 2008). Although there has been exponential growth in research in the fields of transcultural psychiatry (Heaton, 2013; Antić, 2022) and in social science in general on the decolonization of psychiatric practices globally (Applbaum, 2015), there is a lack of research addressing the colonial and post-colonial legacy of psychiatry and the ongoing presence of GMHM in the public health discourse in Bangladesh. Therefore, there is an urgency to develop a better understanding of the "mental health" discourse in Bangladesh that focuses on the historical, political, and cultural transformation of the mental health landscape of Bangladesh in the post-colonial era, which can be addressed by more interdisciplinary and anthropological research.

## 1.2 Paglami and Madness in Bangladesh

The pluralistic medical system in Bangladesh allows for contextualization and categorization of the term Paglami as madness/mental illness/insanity/wisdom. Mental

illness is a term that reflects or associates with a health-seeking and curing agenda; it is an illness of the mind. Whereas the term Pagol/ Paglami gives a broader scope both in theory and methodology. Paglami sometimes implies that there is a permanent or physical defect in the brain that is resistant to treatment or at least resistant to spiritual forms of healing. "Physical defect" can also be seen as an elevation towards an ontology of the world (Callan, 2012). This perception is associated with the saintly powers inhibited by many Pagol figures (Bhattacharyya, 1983). Likewise, the nuances of Pagol include being seen as a mystic, a healer, a homeless wanderer, a suspicious character, or even a political group (Van Schendel, 1985). There is a discursive element to this figure whose perception changes through time (Urban, 1999), and the discussion of this figure opens the possibilities and nuances of how Paglami is seen in Bangladeshi culture. According to Callan (2012), "there is usually little disagreement about whether or not a person is *fagol*[1] (mad). What does get debated is the underlying etiology, and this may be contested within a family" (p.57). Although there are multiple and contested views regarding the etiology of the Pagol in Bangladesh, the category can roughly be arranged under four broad groups: psychological, physiological, spiritual (Callan, 2012, p.57) and socio-economical (Selim, 2010). A person can be Pagol if they worry too much or go through emotional turmoil or shock (Callan, 2012; Selim, 2010). Alternatively, a person can be Pagol if they eat something wrong or something that might disturb the balance of the body (Callan, 2012; Addlakha, 2010).

[1] Callan (2012) uses the Sylheti dialect of Bangladesh where the “P” is replaced by “F” when pronouncing the word “Pagol”. Therefore, she uses “Fagol” instead of the standard Bangla word “Pagol”. Another popular spelling of the term is Pagal.

The existing ethnographic and psychiatric literature in Bangladesh predominantly focuses on the modernist approach to mental illness (Foucault, 1973; Goffman, 1968), which by nature of its history is western-oriented and thus often not reflective of local contexts (Wilce, 2008; Callan, 2012). Although the colonial legacy of psychiatry did not fully replace local healing practices, it did result in hierarchical dominance and tensions among the different ideologies and healing practices in Bangladesh (Bhattacharyya, 1983; Callan, 2012; Wilce, 2008). Bangladeshis find themselves embroiled in a potboiler of competing concepts with epistemological dominance embedded in biomedical etiologies (Bhattacharyya, 1983; Wilce, 2008). In Bangladesh, the health-seeking attitudes of patients depend on various circumstances, such as access to information, mobility, transportation, and personal preference. However, this is further complicated by the fact that most people seek help from more than one practitioner (Callan, 2012; Nuri et al., 2018). However, for the most part, 'mental health' research conducted in Bangladesh (Nuri et al., 2018; Nahar et al., 2014) has been insufficient in addressing the complex interplay between the local and biomedical practices as a result of the country's colonial past.

Wilce (2008) argues that ethnographic, psychiatric, and interdisciplinary research agendas are predominantly designed to replicate biomedical categories by imposing, replacing, and comparing local Bangladeshi epistemologies with biomedical categories that encourage the existing apprehension toward local epistemologies. Wilce (2004) further points out that the moral dominance of biomedical categories is thus creating a detrimental gap in knowledge and practice for people who are suffering as it reframes boundaries between pathways to recovery and the patients who use them. Summerfield

(2012) likewise postulates that the lack of decolonization in “mental health” research, especially in qualitative and ethnographic research, can be associated with the lack of acknowledgement of the colonial legacy and the knowledge produced and implemented in the Global South by GMH arrangements through an unstable, dynamic assemblage of international organizations, academics, professional bodies, and non-governmental agencies in Bangladesh. In short, Bangladesh is like many post-colonial countries in that it still operates on pluralistic modes of healing, which are both simultaneous and diverse at the same time (Ferrari, 2015; Wilce, 2008), and people often find themselves caught between them.

## 1.3 Problematizing Global Mental Health Categories

In the post-colonial era, The WHO plays a significant role in reifying biomedical approaches globally (Brown & Bell 2008), specifically in Bangladesh. For example, the WHO characterizes mental health disorders as a combination of “abnormal thoughts, perceptions, emotions, behaviour and relationships with others” (WHO, 2020). In unpacking this statement, we need to first highlight the notion of abnormality in discussing mental illness. Secondly, we need to point out that it provides a focus on how someone’s mental state can be ascertained as normal or abnormal based on their interactions with other members of society. Both arguments are associated with how psychological knowledge is used by society to control and shape people’s behaviour. As Nicolas Rose (2019) explains, psychiatric categories and practices of diagnosis not only explain and treat, but they also help to set up boundaries to determine who is in need of treatment and for what, alongside the need to establish the notion of normalcy. The

expansion of the scope of psychiatry in our everyday lives is taken up by international organizations like WHO to scale up global health initiatives and interventions to combat the global burden of mental illness. These organizations not only work to highlight the estimation of mental illness around the world, but they also expand the categorization and application of psychiatric categories on a global scale (Rose, 2019; Jakubec, 2009). Some of these dominant categories are depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental disorders, including autism and so on (WHO, 2020). While analyzing the American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM), Rose (2019) states, "each new edition of the DSM has included more categories of disorder, seemingly endlessly expanding the kinds of conditions that are amenable to psychiatric classification and intervention" (p.7). The DSM was established to move towards a more clinical and biomedical mode of analysis, diagnosis, and treatment of mental illness and away from the psychoanalytic approach that focused on a psycho-social analysis. This transition took place to combat the criticism and mockery of the discipline as a mere political practice and to justify the discipline's medical authority and identity by establishing a diagnostic system (Rose, 2019, Horowitz, 2011). Horowitz (2011) explains how one of the most prevalent diagnosed mental disorders during the 1980s, the Manic-Depressive-Disorder (MDD), resulted from interprofessional tension and power dynamics rather than the validity and efficacy of the research. Horowitz argues that the heterogeneous and expansive quality of MDD has resulted in over-diagnosis and false-positive diagnoses among communities as they are used in epidemiologic investigations among untreated community populations in research studies and treatment outcome assessment (2011).

The goal of the GMHM is to establish a universal approach to treatment that blends regional evidence-based data with standard biomedical treatment (Applbaum, 2015). According to the World Health Organization, the alarming increase in mental disorders on a global scale requires country-specific actions. The numbers cited by WHO and supporters of the GMHM have created a notion of a crisis of an epidemic level (Applbaum, 2015; WHO, 2020; Summerfield, 2012). Rose (2019) points out that ethnographies conducted in the Global South have highlighted the exaggeration of numbers and debunked the applicability of a universal mental health intervention that fits all.

The global solution for mental health has been criticized as a distraction from the impact of economic globalization and consideration of socio-cultural contexts (Jakubec, 2009; Hollenberg & Muzzin, 2010; Brown & Bell, 2008; King, 2002). Jakubec & Campbell (2003) point out that there is a predominant lack of understanding of the cultural context within which illness is experienced and the way these needs are met through often irrelevant or unsustainable modes of psychology, psychiatry, nursing, social work, and medicine, and a vast array of goods and services that focuses on resolving the so-called ‘global disease burden’ within targeted nations. Psychiatry's tendency to downplay underlying socio-cultural and political contexts within which ideas of illness and disorder take place is used in order to prioritize and legitimize the supremacy of biomedical interventions (Heaton, 2013). As Johnson (2019) points out, "The DSMs emphasis on the importance of biomedical intervention eclipses the social causes of and social action…” (p.519). These strategies for cure depict peoples' experiences which may divert from a globally contrived norm as needed to be cured, leading to further exclusion and stigma.

Carr's (2006) case study of homeless women's experience in a drug treatment program depicts how language ideologies operate as parameters of healthy practices that the therapists impose on patients in their journey to recovery. In this form of medicalization, institutional mechanisms operate with a hegemonic approach that determines the routes and pathways to recovery and assumes a mind-body disconnection (Scheper-Hughes and Lock, 1987).

## 1.4 Decolonizing Mental Health through Paglami (Madness)

Critics of the GMHM have dubbed it medical imperialism as it champions a generalized mental health model based on Euro-American mental health problems that can be applied to diverse countries and communities (Rose, 2019; Applbaum, 2015). This view reduces the diverse and unique experiences of the diverse peoples living in the Global South and reintroduces the hegemonic ideologies of biomedical practices that marginalize local and indigenous knowledge (King, 2002; Tuhiwai Smith, 2021). It also pushes the ideas of neuroscience and psychiatry as the undisputed body of knowledge and assumes similar results through its application in seemingly different social-economic and political contexts.

I believe Paglami can be an excellent tool for the local translation of mental health practices that encompasses social life and is not reduced by technical and clinical aspects of biomedical categories. Madness has been observed through the lens of power, resistance, and trauma within social sciences. In order to avoid the reductionist clinical approaches of mental illness categories, anthropologists have studied and reframed madness through concepts of trauma between state, economy and political tensions

among institutions, social discord, and structural violence resulting from colonial and post-colonial encounters (Gomory et al., 2013; Pinto, 2020). Pinto (2020) concludes that madness can have a broader explanation that can account for diverse experiences related to mental health, but the analytical discourse of madness is birthed through the same ideological connection and tension within the psychiatric disciplines. Therefore, we must remain vigilant in naming madness as a decolonizing tool for the mental health framework. However, I am asking, instead of seeing madness through the binary tropes of resistance and power, can madness be seen as a way of maintaining social life? Instead of seeing Paglami through the lens of resistance and agency, it can be seen through the modality of everyday life. What I propose here is to understand how Pagol figures maintain their everyday life. Pagol figures take active measures in maintaining a life which should be analyzed from the modality of everyday which I borrow from Veena Das (2007). In a previous small-scale study with the Pagol figures in Bangladesh (Farzana, 2017), I contended that the Pagol figures in Bangladesh do not exist in a social vacuum and their presence challenges boundaries between abnormal and normalcy. The small-scale project was conducted in 2016 using narrative analysis conducted over six months. While my previous project focused on how the Pagol maintains their everyday lives not through just resistance but more so through the performances of identity politics within Bangladeshi society, my MA thesis focuses exclusively on the other side of the coin, an analysis of mental health discourse. Using content analysis and a hermeneutic approach, I will focus on examining the dominant biomedical terms and concepts within selected dominant biomedical and policy texts to develop a comprehensive understanding of how the discourse of "mental health" and illness has impacted the global scene,

especially in Bangladesh where the negotiation between the biomedical categories and local epistemologies are complex and nuanced.

## 1.5 Methodology and Methods

I have drawn upon decolonizing methodologies (Tuhiwai Smith, 2021; Thambinathan & Kinsella, 2021) to critically assess the reproduction of biomedical concepts under the 'mental health' umbrella. Decolonization methodology fits well with my research as it questions the colonial and post-colonial paradigmatic assumptions and methods that undermine local knowledge and experiences of the marginalized population groups (Thambinathan & Kinsella, 2021). I conducted a content analysis based on the hermeneutic approach using secondary materials. The chosen documents consist of one WHO report titled *WHO-AIMS Report on Mental Health System in Bangladesh,* published in 2007 in collaboration with the Ministry of Health and Family Welfare Bangladesh, The National Mental Health Survey Report published in 2021 and implemented by the National Mental Health Institute of Bangladesh with the support of WHO, and the mental health chapter in Bangladesh Health System Review published in 2015 as a collaborative project among various government and non-profit research organizations working in Bangladesh. Additionally, I conducted content and hermeneutic analysis on 20 articles published in top-tier peer-reviewed journals on mental health in Bangladesh to assess the discourse and terminology of biomedicine in "mental health" matters. I believe my sample size is sufficient to support my research claims as qualitative studies usually keep their samples to 100 or less, with an average of 50 (Bernard, 2017, p:114). I used the purposive sampling (Bernard, 2017) method to gather

my data because it does not require me to use any specific sampling design or quota but rather allows me to choose my sample data and sample size based on my own judgment. The samples have helped me to identify similar and divergent patterns that coincide with my research questions. My data analysis shows an overwhelming use of western and biomedical categorization in all the chosen documents and only a handful of mentions of local categories of illness in the journal articles but solely to document the local categories. Through my assessment of the articles published within the past 20 years coinciding with the publication of the WHO Bangladesh documents, I was able to show a pattern in the content of the knowledge that is produced, shared, and distributed by academia and the WHO in their involvements in Bangladesh.

### 1.5.1 Methods

The methods for this study are content analysis and hermeneutic analysis, chosen to build concise and detailed information on mental health studies and policies in Bangladesh. Firstly, a content analysis was done on the purposively selected documents to generate codes and themes to measure the frequency and correlation between the emerging themes. My codes helped me to organize the data under specific themes and categories like-mental health, mental disorder, illness, symptoms, services, healers, words used to describe affliction, the efficacy of the services, gross spending on treatment, different types of treatment, and changing norms and perceptions regarding illness practices. It also helped to elucidate the possible absence of concepts (i.e., local terminologies) within the chosen texts. Using hermeneutics, I was able to elaborate on what is missing in the array of documents. Krippendorff (2013) elaborates that content analysis is a research technique that allows for replicable and valid inferences from texts

and other meaningful matter, such as data derived from printed matter, images, and sounds within the context of their use. Therefore, content analysis is a way to extract explicit and implicit meanings and biases from content (Bernard, 2017). It is less focused on discovering the nature of data and more on the complex relationship with the world within which the data emerge (Krippendorff, 2013). Using content analysis, I explored and interpreted the biases within the mainstream medical journals, which allows them to produce and maintain hegemonic power over local etiologies in mental health research in Bangladesh.

Content analysis does not require prior or deep knowledge of the phenomenon and is a powerful tool which has been used in court cases (Bernard, 2017). On the other hand, hermeneutics is the theory and practice of continual interpretation and reinterpretation of texts which does require a prior understanding of the cultural elements of a phenomenon and a fluency in the language (Bernard, 2017; Paterson & Higgs, 2005). I use hermeneutics as an analytical tool to examine how mental health categories are constructed and practiced in research and policy in Bangladesh. Hermeneutics was initially used to interpret biblical texts during the 17th century, but more recent social science has expanded and developed the role of hermeneutics in philosophy and methodology used to interpret cultural systems and organizations (Bernard, 2017; Paterson & Higgs, 2005; McCaffrey et al., 2012). Hermeneutics analysis is conducted based on our shared knowledge of each other expressed through language (Paterson & Higgs, 2005). This knowledge is further established through the hermeneutic conversation between the text and the inquirer. Through this continual interpretive tendency, the researcher becomes part of the hermeneutic circle, repeatedly moving

between interpretations of parts of the text and interpretations of the whole text, representing an emerging understanding of the phenomenon (Koch, 1999; Paterson & Higgs, 2005). Hermeneutic analysis helped me to center myself within my own cultural context in order to develop a strong and detailed exploration of how mental health categories are strategized against the local backdrop.

I borrowed the idea of the hermeneutic circle inspired by the work of Heidegger and Gadamer (Koch, 1999; Paterson & Higgs, 2005) to analyze my data. The hermeneutic circle is a repetitive and cyclical process of examining the different aspects of a phenomenon before it reintegrates with the whole in order to develop a better grasp of the phenomenon and the relationship between the reader and the texts (Paterson & Higgs, 2005). The hermeneutic process helps researchers to identify their biases and judgements through the process of interpretation and reinterpretation (Bernard, 2017). I used the hermeneutic circle as an inspiration to build and organize my analytical data as a method of "spiralling" (Paterson & Higgs, 2005) between the existing literature, data gathered from content analysis and my research questions. This is a process of identifying emerging interpretations of texts within the selected material and contextualizing them within the emerging themes from content analysis, and then integrating them within the wider analytical arguments based on the proposed research questions. In this way, echoing Narayan (2012),

> "…ideas of which places might appropriately be considered the field have shifted, so too have techniques for fieldwork and modes of representation. Ethnographers now find the field in the familiar and the metropolitan, in archives, markets, corporations, laboratories, media worlds, cyberspaces, and more. Moreover, as places are more complexly connected to other places through the intensifying

> forces of globalization, the field can stretch across networks of sites. …the place you're writing about could be distant or nearby, conceptually demarcated, or far flung. You might be drawing from your own notes and memories, or from accounts produced by others". (2012:26)

The first step of my research was to develop a codebook. The codes were generated through the themes that emerged from my theoretical and previous analysis of the research topic, such as 'mental health' practices in Bangladesh, 'madness', and 'global mental health' categories, etc. I tagged the data set based on words such as: 'madness', 'mental illness', 'mental health', 'mental health conditions', 'mental disorders', 'anxiety', 'stress', 'depression', 'mental health act and policy', 'bipolar disorder', and so on. I entered the codes into NVivo software to allow for systematic, organized, and efficient coding and analysis. I conducted a pretest to ensure that there were no errors and tested the codes' parameters. I chose five articles for my pretest under the different categories mentioned above. After completing the pretesting, I began my analysis of the dataset and organized them. The materials were coded, and words, phrases, and excerpts from the texts were counted and analyzed and compared through the process of content analysis. I used Nvivo software to generate codes to help analyze my data. I applied a deductive approach (Bernard, 2017) to code my data. Deductive coding is done on a set hypothesis; therefore, it fits with my approach as I have already established a hypothesis for my research. The analysis will focus on examining different pathways to decolonizing GMH initiatives by building and arranging data from the samples through the generated themes. I believe my chosen methods will be essential in building a decolonized study based on mental health research in Bangladesh. I will analyze the documents to ask specific questions that are important in decolonizing methodologies, such as "Whose research is

it? Who owns it? Whose interests does it serve? Who will benefit from it? (Tuhiwai Smith 2021, p.10) –what counts as legitimate research, and who are the legitimate researchers and gatekeepers. Equally salient, Josephides and Grønseth (2017) question, "what are the practical implications of the knowledge created and for whom? How does the knowledge created make everyone more capable of dealing with their life concerns? What possibilities does the new knowledge add to everyone's life course and well-being?" (p. 9). These are important questions to ask and to answer as they highlight the power dynamics within the academia and its relationship with international health organizations and mainstream medical journals whose ideas have a significant impact on shaping meaning and practice globally, and in this specific case, Bangladesh.

The following chapters will focus on bridging knowledge gaps in studies of mental health research in Bangladesh by exploring the local categories and epistemologies of madness and affliction and assessing the impacts of GMH categories in the country. It will also explore the capacity of Paglami and madness as a tool for the decolonization of GMH with a focus on Bangladesh. I hope this research will contribute to the expanding literature on mental health and decolonizing methodology in Anthropology by highlighting the complex interaction between biomedical practices and local concepts of illness, suffering, and madness and alternative ways of knowing in Bangladesh.

# 2

# Paglami (madness) and Affliction in Bangladesh

In Bangladesh, Pagol figures can often be identified by physical 'signs' such as their tattered clothing or wearing a red "*gamcha*" (a long cotton checkered towel often used by followers of different saints and patrons). These "signs," in addition to elements such as not maintaining the social decorum of maintaining a respectable distance from unknown women or who do not conform to the norms of public and private space, people who stay disconnected for a long period of time from their families are often considered as mad or Pagol (Callan, 2012). It is important to note that the Pagol figures do not exist in a vacuum outside the boundaries of normalcy. They maintain, negotiate, and navigate within the social systems that brand them as mad, and there is a complex self-awareness of the roles that they play within these systems. As Veena Das (2015) explains, madness is not just the absence of normalcy; it is created and maintained through an intricate relationship between the mad and their social and familial connections. This chapter will take a deep dive into the multiplex of meanings and practices related to Paglami and related illness narratives in Bangladesh. The thesis will address the concerns of GMH categories by first looking at the key etiologies and corresponding treatment practices for mental health in Bangladesh and how these compare to other contexts, which will help us attain better skills to decolonize the hegemonic aspects of GMH approaches. Bangladesh is a lower-middle-income country located in the Global South region of the world. Bangladesh maintains a medically pluralist health care system with a strong focus on biomedical and pharmacological treatment (Callan, 2012). It was the Portuguese who

introduced western medicine and hospital treatment to the Indian Subcontinent. However, the first mental asylum in India was established in 1745 in Bombay (Mumbai) by the East India Company, followed by two other asylums in Calcutta (Kolkata) in 1787, followed by one in Madras in 1794 (Mills, 2000, p.14; Addlakha, 2010; Brumlik, 2014). Calcutta, situated in the western part of the Bengal region, was the hub of the Bengal Presidency, including today's Bangladesh. Another asylum was built in Dhaka between 1815-1819 (Arafat, 2019), and Bengal had the most significant number of lunatic asylums in the colonial era (Mills, 2000). The colonial legacy had a significant impact in shaping the peoples' perspective and practices regarding mental illness in Bengal. Colonization of madness and mental illness by the British regime in Bengal and other parts of the world is in a way tied to the introduction of psychiatry in Bangladesh because it is the British who introduced psychiatry in this region through their establishment and imprisonment of "lunatics" in the asylums they built in these colonies (Mills, 2000; Brumlik, 2014).

## 2.1 The History of Psychiatry in Bangladesh

The asylums in colonial India first emerged at the end of the eighteenth century to accommodate the growing number of Europeans suffering from mental illness (Ernst, 2010; Addlakha, 2010). Most of the European inmates were soldiers thought to be suffering from the strains of socio-political instability, such as the great sepoy revolt of 1857. The Europeans were also thought to have been suffering from the tropical climate of the Subcontinent (Ernst, 2010; Mills, 2000, Addlakha, 2010). The asylums were separated based on race. The native-only asylums were a way for the government to profit through labour exploitation (Ernst, 2010; Mills, 2000; Addlakha, 2010). The

Europeans and the native elites were not expected to do manual labour. The labour was conducted by the native subaltern class (Ernst, 2010; Mills, 2000; Addlakha, 2010; Brumlik, 2014).

At the end of the eighteenth century, the ideas around mental health in Europe were changing. The coercive force was being replaced by institutional incarceration of people deemed dangerous and incapable of assimilating to the standard way of life (Brumlik, 2014, p.2). Although the asylums in India were constructed to take care of the employees of East India Company who were showing mental distress, it soon became apparent to the British that it was a great instrument for subjugation and control over the native population (Addlakha, 2010). Between 1857-1880 the number of asylums increased due to the growing rate of incarceration. During this period, significant changes were made to the law by the colonial government regarding the status and imprisonment of mentally ill people. The government designed new laws to admit inmates who were deemed mad but were not criminally charged (Mills, 2000, p. 12). There are many discrepancies with how the authorities determined the status of one's insanity during the 'lunatic asylum' era. Scholars studying the historiography of the knowledge produced in lunatic asylums argue that the documentation of the information pertaining to the patients cannot be taken at face value as scientific (Mills, 2000; Das, 2015). The asylums were run mainly by superintendents who had no specialization in psy-disciplines. Most of them were general physicians, and some authorities did not have any background in medical training.

Without much information provided in the case profiles of the patients, the deduction of their mental illness was impossible (Mills, 2000, p.12). The ban on Marijuana or Ganja consumption was instigated by the lack of local context and ignorance regarding

evidence-based knowledge. Marijuana was consumed by natives recreationally, but it was also used as remedies for pain relief and inflammation (Mills, 2000, p.32). Most of the knowledge surrounding marijuana in Britain was gained from its uses in India. The British banned the use of marijuana based on contested data regarding the negative impact of the consumption of marijuana which was later reflected in the policies of the asylum. During the 1870s, asylums generated the knowledge that lunacy was caused by Ganja/Marijuana consumption. This was one of the key reasons the government initiated the ban despite any concrete proof for such a claim (Mills, 2000, p. 6-7). The asylum was producing knowledge that was used to shape the social life of the people being controlled by the colonial regime.

Before the dissolution of the East India Company, the asylums were privately owned with no oversight from the government. After Lord Dalhousie took command of the region as the governor-general, he reintroduced the cost-effective, paternalistic, interventionist, and hierarchical framework into the asylum system. The lunatic asylums transitioned into government lunatic asylum (Ernst, 2010, p. 3). Apart from gaining profit from the labour of the inmates, the asylums functioned as a place of control that spilled over to the subjugation of an entire society. The knowledge gathered about mental illness in the asylums perpetuated the power relation between the colonizer and the colonized as the medical and political discourses of colonialism shaped and controlled the lives of the citizens. By having the power to categorize someone as a lunatic based on concepts of western morality, the government imposed a superficial ideology that did not reflect the moral beliefs of the people being imposed upon (Mills, 2000, p.7).

One of the key features of psychiatry is to determine the scope of normalcy. It also has the capacity to determine the production, distribution, and application of knowledge (Rose, 2019, p.8; Summerfield, 2012, p.2, 3-4; Kirmeyer, Lemelson & Cummings, 2015, p. 2). The same power relation can be observed in the colonial production of knowledge. Through the demarcation between sanity and lunacy, the colonial government established the path for the wider society needed to follow to maintain their social status and social life. The asylums' control over individuals and communities can be further observed through the ways patients were marked out and sent to asylums or prisons. While some patients did choose to enter the asylum willingly, most of the patients were forcefully picked by the police. The patients were mostly beggars, wanderers, day labourers, mostly people from the subaltern class who often lacked the support system to protect themselves from the hierarchal oppression imposed on them through the colonialization of mental illness. Even though the law was created to protect the people deemed as lunatics from harm from their families, the implications of this law rarely happened. Instead, the local authorities made more arrests and incarceration than what was approved by the government (Mills, 2000, p.72). The restriction on people's mobility was apparent in both African and Indian colonies (Heaton, 2013). This kind of control and surveillance over the vast number of bodies only exposed the anxiety of the colonial government to control groups of people. In India, the colonial government established 'The Criminal Tribes Act' in 1871, which made the lifestyle of nomadic communities illegal. They were required to stay in fixed places and register for a travel license. One such group was the Barwar living around Oudh, who faced mass illegal incarceration because the British mistook them for "worshiping a deity of theft" (Mills, 2000, p. 72). Individuals who did

not have a regular way of income (wanderers, day labourers, beggars) were targeted by police to restrict their mobility through arrests without having any criminal records or apparent symptoms of mental distress. The jobs given to the inmates in asylums brought profit for the institutions and were also seen as a way of curing lunacy (Brumlik, 2014). The authorities deemed anyone who did not conform to their idea of normal as having a mental disorder. The authorities also describe the natives as lazy and emotional, lacking rational thinking and incompetent to keep up with the competitive world (Mills, 2000). Instead, they were moulded to be "efficient and obedient" through the asylum framework (Mills, 2000, p. 9). Undermining and trivializing the locals' worldview helped to establish the other (Beneduce, 2019, p.714). Before the British era, confinement of the mentally ill was not practiced in Indian society. The ascetic lifestyle in South Asia allowed for the tradition of wandering or vagrancy (Brumlik, 2014, p.1). Unprecedented changes in social perception and practice regarding mental health changed due to the involvement of British rule, and by the early 19th century, psychiatry, especially colonial ethnopsychiatry, became an integral part of the colonial welfare regime that perpetuated further racial division within the society (Addlakha, 2010, p.4). Although colonial asylums were intended to be the replica of their British counterparts, in reality, concepts of mental illness and the function of asylums were greatly modified by the colonial experience. Therefore, creating a hybrid version of colonial psychiatry steeped in racial prejudice and discrimination (Basu, 2005; Ernst, 2010, p.16). The same modification can be seen in other political and social aspects like public health, legal regulation, and social welfare of the British liberal-capitalist society in colonial India. Despite not having the same effect of integration in different layers of Indian society, the ideological power of

welfare was persistent in peoples' minds. It worked as a legitimizing process to justify colonial rule to the British people. The assumption was that it was done in the name of human progress based on unbiased scientific knowledge (Ernst, 2010, p.17). Psychiatry, as a part of western medicine, also imposed its legitimacy and necessity as a tool for the betterment of people.

The hegemonic stance of western healing systems was used to discredit and disregard the local healing practices and epistemologies as superstitions and barbaric practices observed by the natives (Ernst, 2010, P.17; Hernández-Wolfe, 2013, p.9; King 2002). There were stark differences in the level of access that the natives had to western medical treatments to Europeans. The number of native mental patients treated in asylums was far lower than the Europeans. Still, psychiatric practices and western medicine were part of the public consciousness due to their ideological and symbolic presence (Ernst, 2010, p. 19). On the other hand, Heaton (2013) argued that colonial psychiatry had no effect in Africa as most people had little to no contact with the authority or the asylums. The asylums were situated in urban places and were only for violent criminals. And most African citizens had no faith in the psychiatric practices of the colonizers.

Psychiatry played an important role in maintaining the colonial cause and its discourses. The colonial legacy of psychiatry has shaped how mental health practices are performed in contemporary societies. The imposition of a hegemonic western healing system onto a distinctly diverse culture has raptured the fabric of the colonized population and their connection to their knowledge systems. That does not mean that local and traditional knowledge has been erased from our lives. Local and traditional knowledge in South Asia have resisted, adapted, and thrived under colonial hegemonic oppression (Mukharji,

2014; Callan, 2012; Addlakha, 2010; Basu, 2005). However, there is a knowledge gap regarding the history and progression of local knowledge in mainstream consciousness. Most of our research regarding mental health in the Global South and Bangladesh has been done from a western gaze (Hasan et al., 2021; Radford, 2005; Basu, 2005). There is a need for decolonization in studying the role of psychiatry in the Global South through the exploration of history and culture. In explaining the need for discovering the progression of Indian psychiatry, Basu (2005) explained, "the ahistorical and acultural understanding has prevented us from exploring the conceptual issues that are specific to Indian psychiatry. We are still struggling to erase the lack in Indian psychiatry in relation to the Euro-American one" (p.129). The colonial aspects of psychiatry have created a sense of insecurity and awkwardness among Bangladesh's psychiatrists and mental health professionals. The knowledge gap is caused by the lack of understanding about the local practices, and prejudice is created based on colonial hegemony. Most doctors in Bangladesh practicing psychiatry are resistant and dismissive of the potential of other healing methods that do not subscribe to the positivist and reductionist applications of modern psychology (Wilce, 2008).

There is an urgency to develop a better understanding of the mental health discourse in Bangladesh that focuses on the historical, political, and cultural transformation of the mental health landscape of Bangladesh in the postcolonial era. The lack of research on the decolonization of psychiatric practices and the direction of psychiatry in Bangladesh in general needs to be addressed from an interdisciplinary context.

## 2.2 Mental Health in Bangladesh

Recent research on mental health in Bangladesh shows that the number of mental health patients has been growing in recent years. In 2015, among the 161 million people, 16.1% of adults and 15.2% of five- to ten-year-old children were suffering from some mental disorder (Nuri et al., 2018). In 2018, the WHO estimated that neuropsychiatric disorders in Bangladesh contribute to 11.2% of the total disease burden (Nuri et al., 2018). In spite of these increases, mental health care is inadequate, and the services are disproportionately distributed in Bangladesh.

As Nuri et al. (2018) noted,

> "..like many other low-income countries, mental health has not received adequate attention from the Bangladeshi government. Bangladesh has one mental health institute, named the National Institute of Mental Health (NIMH), which has a 200-bed specialized mental hospital attached to it. In addition to the NIMH, there is another 500-bed mental hospital (Pabna Mental Hospital, located 162 km west of Dhaka), 31 community-based psychiatric inpatient units, 15 beds in forensic inpatients units, 3900 beds in residential facilities (e.g., homes for the destitute, inpatient detoxification centers and homes for people with mental disability) and 50 outpatient mental health facilities in the country" (p.2).

As a medically pluralistic society, mental health services in Bangladesh are provided through both biomedical and non-biomedical practitioners (Callan, 2012). Patients often choose service providers based on availability and accessibility (Nuri et al., 2018). However, mental healthcare in Bangladesh is massively inadequate due to a lack of

funding, scarcity of skilled healthcare providers, and social stigma related to mental health, which affects the patients and their families (Nuri et al., 2018). There are multiple pathways to care regarding mental health in Bangladesh. Even with the dominant presence of western biomedicine, the folk and local healing practices have not subsided. The resilience and resurgence of non-biomedical practices directly result from the versatility, adaptability, and borrowing of biomedical models by local healers than social class elements (Callan, 2012). While the existing literature suggests that non-biomedical practitioners often overlap local and biomedical knowledge to treat their patients (Callan, 2012), we do not know if practitioners of western psychiatry in Bangladesh incorporate alternative and indigenous healing techniques in their treatments. Focusing on the treatment practices of psychiatrists and medical health professionals will help us understand whether the cultural categorization of mental illness affects the etiology and treatment practices. In order to understand the coexistence and negotiation between biomedical and non-biomedical treatments, it is imperative to do a colonial and postcolonial discourse analysis of psychiatric practices through the exploration of colonial bio-medical and psychiatric practices in Bangladesh as well as the comparison and analyses of the colonial and contemporary policy documentation on mental health and practices in the context of Bangladesh and the Indian subcontinent.

## 2.3 The Etiology of Madness and Mental Illness in Bangladesh

A person can become Pagol under various underlying circumstances in Bangladesh, but what is not debatable is the signs and symptoms that mark someone's experiences of suffering, illness, or even accession to a higher place for wisdom and

power which all can be deemed as Paglami or going Pagol (Callan, 20212; Mukharji, 2014). Various psychological, physiological, spiritual, and socioeconomic causes can bring about this transition in one's life (Callan, 2012; Selim, 2010). A person can go mad if they worry too much or go through emotional turmoil or shock (Callan, 2012; Selim, 2010). A person can go mad if they eat something wrong or something that might disturb the balance of the body (Callan, 2012; Addlakha, 2010). Eating beef, duck eggs, or hot food can cause mental illness or madness. Permanent brain damage can be sustained if someone has high blood pressure. Pregnant and post-natal women are at high risk of suffering from madness if they eat hot food or touch something cold. Lack of sleep can also cause problems in the brain (Callan, 2012).

In most cases, various external factors cause the brain to overheat or "*matha groom"* (hot head), resulting in brain damage. The Yoruba in Nigeria believes that certain spirits can blow hot air into people's mouths, resulting in their minds being heated and causing madness. Brain damage can mean both madness and mental illness. Some of the conditions can be cured. Others cannot. Other than madness, these factors can also trigger other illnesses such as headache (*matha betha*), head spinning (*matha ghurano*), which is similar to dizziness, and head biting (*matha kamrano*). All of these can get triggered by stress or exposure to heat. Psychiatrists can treat these symptoms, and they are called brain doctors by most Bengalis (Callan, 2012).

During 2006-2007, Nasima Selim conducted a qualitative study in two villages in the Matlab region of Bangladesh to explore the cultural dimension of depression in rural Bangladesh. The results revealed a significant number of villagers to be suffering from depression. The village doctor, a biomedically trained professional, also felt that there

was no difference in the number of people suffering from anxiety and depression in both rural and urban settings. The research was designed to shed some light on the local knowledge around depression. Although the locals had never heard of the term depression or its Bangla translation, *"Bishonnota*," they were able to identify the symptoms discussed in the vignette as "*Chinta rog*" (worry illness), "*Chinta"* (worry), "Tension" (anxiety), "*Tension rog"* (anxiety illness), "Brain stop" (brain stops functioning), "*Orthonoitik* (financial) *durbolota* (weakness)", "*Mathaye* tension" (tension in the head), "*Hridkampo/buk dhorfor"* (palpitation), "*Hai hutash"* (grievances), "*Manoshik rog"* (mental disorder) (Selim, 2010, p.99). The participants identified a wide range of physical, social, and emotional problems as stressors that would trigger feelings of dizziness, ache, pain, fatigue, shaking, and burning sensation associated with depression (Selim, 2010). They believed the illness originated from the brain and then it spread to the body. The critical condition which overlaps with others is financial trouble and poverty. Most people worry about not being able to sustain their lives or having too many daughters resulting in dowries that they cannot afford to pay—causing them to have Chinta rog or anxiety. Depression can manifest from worrying about one's physical illness. The participants believed that recovery could be achieved by alleviating poverty, financial distress, and medication. The researcher noted that the villagers had high faith in pills for pain relief. There was a high preference for biomedical treatment and choosing a doctor over a local folk healer among the participants. This view is contested by Callan's (2012) work in the Sylhet district in Bangladesh, where she found that although patients frequented the chambers of doctors and psychiatrists, they had a strong sense of mistrust of doctors and professionals in general. She also noted that the doctors

would prescribe medication within five minutes or sometimes within three minutes (Wilce, 2008) into the session, and patients were always happy to take them without any questions. Biomedical treatment is widespread in Bangladesh, and often folk and religious healers and untrained medical professionals would use biomedical treatments alongside traditional and local healing practices to attract patients. The healers sometimes borrow aspects of biomedical explanatory models to treat their patients (Callan, 2012). Selim's (2010) study found that the village's healthcare professionals, NGO workers, and doctors preferred more psychosocial treatments for anxiety and depression among villagers.

Sorcery can be considered another cause of mental illness and madness in Bangladesh. Sorcery is a way for a person to bring misfortune to another with the help of a spirit. A victim of sorcery can have prolonged distress and illness with little to no drastic symptoms. On the other hand, spirit possession can last a few weeks with bouts of sudden mad behaviour and speech (Callan, 2012, p.58). This is similar to people experiencing the evil eye in India, Nigeria and many other parts of the world. In West Bengal, India, it is believed that the evil eye (Najar) can bring about any illness through the agency of another human being who is willing to harm another through the help of a sorcerer or a witch (Ferrari, 2015). While in Bangladesh, recovery from sorcery is either through a religious healer or a psychiatrist.

It should be noted that psychiatrists in Bangladesh mainly do not subscribe to traditional or local explanatory models, and they diagnose patients according to western models (Wilce, 2008). In India, "the counter the effects of the evil eye, the "knot" is supposed to be untied by a healer, an exorcist, or a specialized Brahman or people from special

occupational classes" (Ferrari, 2015, p.5). In Nigeria, mental illness is caused by curses, social taboos, evil eyes, malevolent spirits, and witchcraft (Heaton, 2013, p.156).

Spirit possession plays a considerable role in explaining mental illness and madness in Bangladesh. There are multiple ways a person can become afflicted by a spirit. Spirits can be both benevolent and monovalent. The possession can bring both higher status and social scrutiny for people. In most cases, spirit possession ensures that as the result of offending, a powerful figure or a deity and recovery is gained after appeasing them through some form of prayer and sacrifice (Callan, 2012, Ferrari, 2015). In Bengali folk healing, illness is seen as injustice and divine punishment (Ferrari, 2015). In Bali, "it is a common belief that if these complex and costly rituals are not followed exactly, the spirits being propitiated will become upset, leading to a variety of misfortunes, such as illness or financial hardship" (Lemelson & Tucker, 2015). There is a strong notion of morality associated with mental illness. In Bangladesh, madness is seen as deviant self-assertiveness and abandonment of duties, responsibilities and social and gender roles. It can manifest through women's lament or weeping and autonomous movement, which violates their gender roles. Although spirit possession is the cause of losing control over one's body and mind, it is believed that women who do not maintain proper "*parda*" or veiling are the ones getting possessed (Callan, 2012). Mills (2000) points out that the asylum regime in Europe was a way to keep women within the patriarchal chains. During the 1880s in Australia, asylums were operated to reform the "fallen women" in society by making them do womanly chores like laundry. "Reform or recovery in women was very much judged in these institutions not by reference to some natural standard of health and

illness but by reference to a standard of behaviour derived from the social and cultural discourses of patriarchy" (Mills, 2000, p.37).

In Bangladesh, spirit possession in women can also be viewed as a way for women to exercise their agency. Going Pagol allows women to transcend and navigate through patriarchal norms. The *firnis,* or female saints in Bangladesh, have gained favour from a powerful spirit. This new status allows them to perform as spiritual healers. Thus, gaining status in her society. Callan (2012) mentions an episode in her book regarding one of the saints she was interviewing-during the interview, she started having episodes of mental breakdown, which started right after her marriage. Due to the virilocal practice in Bangladesh, she was sent to live with her husband's family. Callan argues that Sylheti women's sudden mental illness after marriage is a way for women to reject the virilocal practice. The daughter-in-law is often subjected to severe otherness and abuse because of their outsider status due to the virilocal practice of women moving to their husband's families after marriage. Women often experience severe mental breakdowns, which gives them an outlet to express their dismay and pain. Discussing "*firnis*" (female saints), Callan shows how these places of healing and worship are places for people, especially women, to take back some of their agency by looking for ways to improve their situations.

The above discussions show that there are many nuanced interactions among different healing systems in Bangladesh. Bangladeshis have access to various local and folk healing treatments other than biomedical treatment. So, it is essential to assess the possible outcomes of available practices in the context of the country. Alternative explanations can help to reframe the hegemonic western explanations that may not

always fit with the culturally nuanced and diverse landscape of mental health and illness in the Global South. Many alternative healing practices focus on healing and not just curing. Here, healing focuses not only on the 'functionality' of the patients but it primarily indicates a more inclusive approach for patients to remain integrated into their social lives (Radford, 2005). In other words, we need to consider whether the decolonization of this complex landscape is the way forward.

## 2.4 Decolonization with a Question Mark

The global mental health movement has garnered much controversy over the last decade, leading one to consider whether decolonization is the key to moving forward (Mills, 2014). Indeed, mental health practices are situated within systems of power and colonial hegemony that produce neocolonial tendencies by dismissing the experiences of generational trauma and the eradication of peoples' cultures and illness narratives (Ludtke, 2008; Millner et al., 2021). Global categories of health and mental health also push the ideas of neuroscience and psychiatry as the undisputed body of knowledge and assume similar results through their application in seemingly different social-economic and political contexts (Rose, 2019; Summerfield, 2012). With the help of international organizations like WHO, leaders and supporters of the GMHM have been piling up numbers and statistics that indicate that we have an epidemic-level crisis at hand with the alarming rate of growing MNS (mental, neurological, and substance) disorders around the world. Such significant numbers are used to draw attention to the plight of people suffering from different neuropsychiatric illnesses (Beneduce, 2019; Rose, 2019; Summerfield, 2012). The GMHM aims to create better outcomes for people with mental

illness through proper policy implementation, which would make a difference in people's lives. The goal is to create effective action that builds awareness of stigma and pushes governments to adopt better mental health care systems. One of the critical factors here is access to psychopharmacological drugs for mental health patients. Pharmaceutical drugs are a big part of contemporary biomedical interventions. These are seen as essential drugs that should be distributed to lower and middle-income countries (LMICs) to bridge the mental health gap. Critics argue that the numbers presented by GMHM were not always based on unbiased clinical trials, as many big pharmaceutical companies hire researchers to bring in numbers that are favourable for the company (Beneduce, 2019). The push towards research solely based on statistical findings dehumanizes approaches to studying mental health. Considering the ambiguity and overall lack of knowledge about the nature of the efficacy of these drugs, it is questionable to see their widespread presence in LMICs. Ethnography conducted in India shows that thousands of generic psychopharmaceuticals are sold privately and prescribed to millions of people through knowledge circulated by pharmaceutical representatives (Ecks & Harper, 2013). The same can be seen in other countries like China, Brazil etc. Moreover, this is not being added to the database because it is not showing up as it is sold in a private market. Without having a good understanding of the local policies and socio-political practices, it would be unwise to establish policies and interventions based on models from elsewhere (Rose, 2019, p.78). Although, the leaders of the GMHM argued that in order to address the problems on a much larger scale, it is necessary to build standardized and cost-effective interventions that different donors and governments can adopt. It is very important to address how mental health distress and trauma are being operated within

different cultures, but it cannot be done by ignoring local contexts in favour of a one-size-fits-all model. The urgency for intervention has brought into question the necessity for anthropological knowledge and data due to anthropological research's time-consuming and extensive nature (Summerfield, 2012). It is imperative to conduct qualitative research based on an anthropological framework to gain complex and nuanced information vital to understanding what is empirical.

To summarize, a few key factors shaped the emergence of GMH discourse. One of them is the notion popularized by transcultural psychiatry that while the manifestation of different mental disorders was culturally specific, they were just different ways of expressing the same illness experienced universally. Secondly, the emergence of DSM and ICD categories, which were thought to have universal applications, helped establish psychiatric epidemiology. Thirdly, DALYs (disability-adjusted life years) were introduced to measure mental disorders' social and economic costs. Fourth is the popularization of evidence-based medicalization with bias and blind faith in producing accurate and apolitical scientific data. Lastly, it is the belief that stigma and discrimination regarding mental health issues in LMICs prevent people from getting diagnosed and receiving the help they need (Rose, 2019, p.74). The GMHM aspires to answer and embody all these aspects. This has resulted in the debate that has made GMHM one of the most pivotal and contested topics of our time. The supporters of this movement denounce the critique of their approach to establish a westernized notion of mental health categories as imperialistic. They argue that the movement takes note of diversity and takes possible steps to include local healers for their knowledge and role in the community network system to introduce new mental health agendas (Beneduce,

2019). However, this does not necessarily work as an equal partnership. It is more like a management process to build on the community's trust through familiar engagements. Community interventions help establish western categorizations of mental illness, pushing aside the existing local categories.

As Summerfield (2012) states, projecting indigenous non-western categories as equivalent to psychiatric categories is a way for western categories to avoid exploring the limitations and boundaries of their knowledge and epistemological practices. Their universal validity has not been proven, but that has not stopped them from being used as a standard category to measure and explore global mental health status. Using western mental health categories in quantitative methods as parameters to generate findings in other parts of the world undermines the local etiologies of mental illness. For example, a qualitative study was done in Bangladesh to explore the cultural dimension of depression among rural Bangladeshis (Selim, 2010). The researcher used the category depression to lump together various local illnesses to show the frequency of a hidden mental disorder among the villagers to highlight the importance of mental health awareness. Although, none of the research participants except for trained biomedical health professionals identified their illnesses as depression. Little attention was paid to the local terminologies or illnesses; instead, it was an effort to fit them into a box to prove that depression exists in this part of the world.

When the term depression was introduced to Latvian society through the International Classification of Diseases (ICD) categories by pharmaceutical reps, psychiatrists, and doctors, it replaced the local term "*nervi*", which closely translated to distress

(Summerfield, 2012). The sudden shift displaced peoples' narratives from identifying with a social discourse to feeling responsible for their struggles.

> "The shift from *nervi* to "depression" represented the internalisation of a heightened sense of personal accountability for one's life circumstances – but at the very time when post-Soviet Latvian society and economy had lost much of its former sense of stability and security" (Summerfield, 2012, p.4).

One of the criticisms of psychiatry is its link with the neoliberalist practice of market economy, competition, individualism, personal responsibility and self-improvement through individual entrepreneurship (Rose, 2019). This individualization of pushes people to internalize their struggles. They have primarily operated in isolation away from everyday realities, even in community interventions. Therefore, it loses the entire point of community building. "The political and economic order benefits when distress or dysfunction that may connect with its policies and practices is relocated from socio-political space, a public and collective problem, to mental space, a private and individual problem (Summerfield, 2012, p.3)." Therefore, cultural contexts are critical for mental health as it helps to identify how people in different communities deal with mental health issues under different socio-political circumstances.

Although a handful of researchers in the global mental health movement suggest a lack of effectiveness, that does not mean the issue of the movement will go away any sooner (Summerfield, 2012; Kohrt & Griffith, 2015; Millner et al., 2021). Therefore, the best way to deal with this situation is to find effective ways to answer critical questions regarding the implications of GMHM interventions in LMICs. Ethnographic studies will help answer our queries better than most other methods as they were the first to question the legitimacy of the claims that the movements have made about many LMICs (Rose,

2019; Biehl &Petryna, 2013). Ethnographic studies on indigenous and local etiology and mental illness epistemologies can help bridge the knowledge gaps, especially in the context of the colonial history of psychiatry. "Psychological anthropology has developed methodologies to explore the complex dynamics of subjectivity, intersubjectivity, phenomenology, and interpretation that shape mental illness in social situations based on local models and understandings of illness and social behaviour" (Lemelson & Tucker, 2015). Health is not a universal concept, and there are various ways for people to explain their conditions. Even with the domination of biomedical practices, many countries still operate on pluralistic modes of healing which are both simultaneous and diverse at the same time (Ferrari, 2015). The surge, over the last couple of decades, surges in interest in interactive medicine or interactive health care that combines biomedical practices with various traditional, complementary, and alternative healing systems to balance social and biological models (Lemelson & Tucker, 2015). Research in mental health practices in the Global South has great potential for an integrative approach. Most South Asian countries have a thriving medical pluralistic society where local and traditional healing systems navigate and adapt alongside biomedical practices (Callan, 2012; Mukharji, 2014; Ferrari, 2015). In Bangladesh, mental health care is provided by biomedical and non-biomedical practitioners such as folk healers, religious healers, and traditional healers. The health-seeking attitudes of patients depend on various circumstances, such as access to information, mobility, transportation, personal preference etc. However, most people seek help from more than one practitioner (Callan, 2012; Nuri et al., 2018). In India and Bangladesh, Ayurvedic, Unani, and Homeopathic models of healing are practiced alongside western biomedicine. More research in identifying how these interactions

happen and what key factors are involved will better understand different and effective recovery models. The interactive model addresses the causes, courses, and outcomes of illness by exploring the complex interaction between factors such as biology, family, and community because cultural factors like family and community can act as triggers and support recovery.

Like the global mental health movement, there are multiple areas of concern that need to be addressed here. Complementary and/or alternative medicine (CAM) is being integrated into health care worldwide. WHO is organizing health policies on CAM. Hollenberg & Muzzin (2010) argue that there are some fundamental challenges to the application of integrative medicine. From an anti-colonial perspective, some risks entail the devaluation, assimilation, and appropriation of CAM by the Eurocentric biomedical model. They also point out that this interaction may also lead to the marginalization of CAM practices through the hegemonic oppression of biomedicine. One of the biggest questions here is who gets to decide which view would be represented and which one would be excluded (Hollenberg & Muzzin, 2010).

There is always tension between biomedical and CAM practices. Scholars have noted that knowledge related to health and well-being from the Global South has always been looked down on by the North (Hollenberg & Muzzin, 2010). Hollenberg & Muzzin, in their study based on two medicalcenters in Canada, found different levels of resistance tension present between biomedical practitioners and CAM practitioners. According to the study, physicians were apprehensive about suggesting CAM to their patients because of their lack of validity in biomedical literature. One of the doctors stated, "I think it is malpractice to push them to the alternative. In fact, our job is to try to convince them to

take the proven form of treatment" (Hollenberg & Muzzin, 2010, p.13). This is a standard view among most biomedical practitioners. However, they insisted that they have no problem collaborating as long as it proved that the CAM practice was safe. CAM practitioners also complained of being compared to the standards of biomedicine. A very different picture can be seen in Indonesia, where two people who suffer from mental disorders have found a comfortable life outside of their illness due to people's integrative perspective towards mental illness. A Balinese Hindu grandmother living in a rural setting diagnosed with paranoid schizophrenia and a Javanese Muslim man diagnosed with schizoaffective disorder living in the urban setting learn to navigate their lives with their condition. Aside from biomedical treatment, they have the support of their family and community, allowing them to maintain their everyday lives (Lemelson & Tucker, 2015). The integrative aspect here is that they can choose aspects of the healing process that best fits their situation.

Mental health discourse has vastly shaped the era in which we are living. Throughout the debate on global mental health, the concept of cultural context and the need for interdisciplinary psychiatry were established. This push towards collaboration between anthropologists and psychology signals the need for better explanations of how biological and social aspects regarding mental health and illness are connected. On the other hand, the connection has launched some new methodological and theoretical prospects that may help us find a better balance. It also shows how ideas of health and illness are shaped by intersecting bodies of knowledge in the Global South because of the colonial legacy and the changing landscape of global politics. Contemporary research in the Global South has shown how traditional medicine is being rebranded and commodified through national

and transnational politics as means of the health categories (Bode, 2006). Therefore, a methodology of decolonization which questions the dominant categories and attempts to understand local meanings can help us to establish a better route as we move forward.

# 3

# The “Package Deal” of Mental Health Research in Bangladesh

The validity of mental health research has been called into question by various researchers over the years (Summerfield, 2012, 2013; Applbaum, 2015; Beneduce, 2019; Rose, 2019). This chapter, in essence, is a validation of the arguments made against global mental health research based on the context of Bangladesh. It may seem redundant to reproduce the same narratives regarding mental health research, and it could be argued that it brings nothing new to the table. I would argue that redundancy in this context does not work against my agenda to decolonize research in mental health through the exploration of madness. Rather it amplifies the need to question the translatability of a western-centric universal model of mental health in countries like Bangladesh, located in the Global South. Unlike countries like Nigeria, where research in mental health has flourished through transcultural psychiatry (Heaton, 2013), mental health research in Bangladesh does not have a long history. Only a handful of research has been conducted in the area of mental health and illness over the past decade. Yet during this time, the research has rapidly and aggressively transformed the dominant concepts that Bangladeshis draw upon to articulate. Hence, while the trajectory is short, it is still vitally important to explore since the research filters down to frame public and global opinion. Hence, this chapter is a critical analysis of the mental health research being conducted in Bangladesh. For the purpose of this analysis, 20 articles from various different journals and three government and WHO reports have been chosen for both content and

hermeneutics analysis. Content analysis is used here to systematically go through and analyze a large number of textual data to draw out patterns within the texts. It is also a way to create shared meanings that arise from the analysis of the words and codes from the chosen materials (Krippendorf, 2013; Stemler, 2000). Here, the method is used to understand the shifting opinions and meanings assigned to words as well as how the data is being arranged and contextualized according to the proposed arguments of the thesis. The understanding of the data is further developed through the technique of hermeneutic analysis because it complements the process of content analysis by allowing for a deeper understanding of the texts. Through the process of iteration, the content is interpreted and reinterpreted from the analyst's own understanding of the world and, therefore, helps to minimize errors of interpretation from just the initial content analysis (Krippendorf, 2013; Bernard et al., 2017). This method of analysis allows for a more layered understanding of the chosen dataset. As the chapter explores the way mental health knowledge is produced, shared, and materialized through research, it not only traces the patterns of interpretation by the researchers but also my own. I believe through the exchange of different interpretations of meanings attached to 'mental health', illness and peoples' experience of suffering; we can establish a more robust approach to research in Bangladesh.

The chosen journal articles and the government and WHO reports are a well-established lens into the Bangladeshi mental health discourse. The articles analyze different stressors for mental health conditions from a biomedical perspective concerning the future and development of mental health research and policies in Bangladesh. The emerging themes are the underlying socio-economic stressors that guide the perception and treatment of

people suffering from mental illness and mental health policies and services in Bangladesh (Mullick, 2002; Nahar et al., 2011; Hossain et al., 2014; Nahar et al., 2014; Uddin et al., 2019; Islam and Biswas, 2015; Akhter et al., 2017)

There are three main goals that can be identified from the research done in Bangladesh: Firstly, much of the work has been done to address the lack of research and the low mental health literacy rate within the population (Mullick, 2002; Nahar et al., 2011; Hossain et al., 2014; Nahar et al., 2014; Uddin et al., 2019; Islam & Biswas, 2015; Akhter et al., 2017; Hossain et al., 2018; Islam et al., 2018; Mamun et al., 2019; Tasdik Hasan et al., 2020; Karim and Shaikh, 2021; Arusha and Biswas, 2020; Hayward and Ayeb-Karlsson, 2021; Alam et al., 2021; Banna et al., 2022; Khan et al., 2021; Hasan et al., 2021; Chowdhury et al., 2021; Faruk & Hasan, 2022; Rahman et al., 2022; Koly et al., 2022). Secondly, researchers have tried to explore the consequences of knowledge gaps and the lack of understanding of global mental health concepts leading to a wide variety of misconceptions, stigma, and indifference toward the growing mental health crisis (Nahar et al., 2014; Uddin et al., 2019; Islam and Biswas, 2015). And lastly, researchers have strived to encourage mental health initiatives and policy implementation by the government of Bangladesh following the seemingly successful programs conceived by WHO and other international organizations (Chowdhury et al., 2021; Faruk and Hasan, 2022; Rahman et al., 2022; Koly et al., 2022). At the heart of all of the research is the idea pushed forward by the GMHdiscourse that we are in the middle of one of the biggest mental health crises in history, and the way path forward is through scientific investigation of the concept of illness, health, and treatment options which often are synonymous to the western biomedical ideology and practices (Millner et al., 2021;

Tuhiwai Smith, 2021). This universal "package deal" is replacing and removing the existence of local epistemologies and explanations of illness, suffering and diseases themselves (Beneduce, 2019) through the form of research. Below, *Figure 1* is a word cloud generated via NVivo to highlight the 50 most used words in the dataset.

Figure 1: Word cloud of 50 most used words in the selected dataset generated by NVivo

“Mental Health” is at the heart of the ontology, and we find this to be the case in all the documents. The word cloud showcases the essence of the articles and the reports as an avenue to translate and transport the western mental health categories into research, policy and government-backed acts and laws in Bangladesh. The most frequently used terms in the dataset are all used to describe and analyze the GMHsituation, such as mental health care, disorders, mental health conditions, community, services, and training, among others. There is no mention of any local terminologies or madness. Although the biomedical presence in Bangladesh has carried on from the colonial era, it has seen overwhelming urgency in the era of globalization and global politics imbued in the GMHMwith much vigour indeed (Koly et al., 2021). The following sections of this chapter will critically discuss the arguments presented in the selected research conducted in Bangladesh that make up the genre of mental health and illness, focusing on the eraser

of local etiologies of illness and Paglami. The discussion around this topic will tie in with my argument of decolonizing methodologies in research and the legacy of colonialism and GMHpolitics that shape our understanding of who we are through our perception of illness, suffering, and affliction.

## 3.1 The Burden of the Mental Health Crisis in Bangladesh

Kalman Applbaum aptly asked the question of how 'global mental health' has become a normative term that can be evaluated through medical and epidemiological interventions and can be subjected to strategies for improvement (Applbaum, 2015). The pathway towards building a global campaign against an illness of epidemic proportions requires political knowledge that is shared throughout the world by a trickle-down method where the journey starts from the Global North and ends at the Global South. As argued by many, mental health is a hegemonic colonial system of power that has established itself as the way forward in dealing with the burden of the global health crisis (Millner et al., 2021; Tuhiwai Smith, 2021). As Summerfield (2013) points out,

> “The blithe universalism underpinning global mental health is reproducing the dynamics of the colonial era: the colonized were typically spoken for and unable to control the way they were represented. A salient trait of modern imperialism is to claim to be a progressive movement, setting out to instruct, modernize, and civilize, with Western knowledge taken as definitive” (p.2).

Global mental health strives to bridge the gap in care and services around the world by creating universal approaches to meet the diverse needs of people around the globe, especially in the Global South (Applbaum, 2015; Lemelson & Tucker, 2015; Summerfield, 2012). The WHOand the advocates of the global health movement have

established the movement as a way of aiding the countries in the Global South that are in desperate need of strengthening their mental health infrastructure (Applbaum, 2015; Lemelson & Tucker, 2015). There is an overwhelming sense of authority in constituting the western ideas of mental health categories as a universal solution that can be translated between multiple worlds. This form of centralization of western categories can be seen as hegemonic and imperialistic as it questions the validity of the existing local practices and knowledge systems in the Global South by declaring itself universal and stating itself as the only power to be able to do so (Summerfield, 2012; Beneduce, 2019). This approach is in stark contrast to the local healers of the Global South who see their form of practice catered within their specific cultural contexts and as one of many ways of treating and healing patients covering a myriad of illnesses from mental health issues to sexual disorders and spirit possessions (Summerfield, 2012; Callan, 2012; Das, 2015).

Classifications are ways for people to assign order and meaning to their everyday lives. Bowker & Star (2000) argue that it is embedded in our everyday practices, whose ordinariness often renders it invisible. By assigning classifications and categories to things, we bring forth and make certain aspects of our lives invisible. It is a process born across time and space. Therefore, classifications are situated within specific historical contexts. They are not an ideal expression of our cognitive mind through the creation of artifacts. Classifications are flexible, not mutually exclusive, and they change over time. There is a strong emphasis on seeing them as standards and ideal types, but it is almost impossible to do so as the "standards" are not often chosen based on the best possible representation of a universal idea but rather on the treads of political and ethical practices assigned by few (Bowker & Star, 2000). Therefore, we need to pay close attention to how

classifications are created, maintained, and applied in our everyday lives. The argument is not about getting rid of classifications but rather about what do these classifications mean to us and how they shape our lives. It is important to understand the underlying mechanisms that maintain this method of assigning order to our lives, as classifications do not stand alone. They are always interdependent on other ecological systems (Bowker & Star, 2000). Classifying our experiences of suffering helps to make sense of the interruptions in our everyday lives (Das, 2015; Bowker & Star, 2000). However, classifications are not universal standards that are inclusive of all experiences. Therefore, it is important to understand the politics of classifying that aims to create a standardization of certain narratives and knowledge systems (Bowker & Star, 2000). Despite their flexible and changing nature, once an artifact or idea has been introduced within a classification, its existence is unavoidable. Classifications can be hierarchical and contested within their own scopes. The standardized universal categories are created through negotiation and conflict as the decision to make things invisible and visible is maintained through political power dynamics (Bowker & Star, 2000). This can be seen in the mental health classifications and categories promoted by the GMHM. As Kohrt and Griffith (2015) explain,

> "Furthermore, within both high and low-income settings, economically and educationally privileged groups tend to create policy and shape infrastructure for mental health care of more vulnerable groups. Regardless of how GMH professionals attempt to partner with members of the target population, the relationship remains an asymmetrical one in terms of power, scientific knowledge, and material resources" (p. 603)

The policies and infrastructure for mental health in Bangladesh are shaped by the western psychiatric and psychosocial models promoted by the GMHM (Nahar et al., 2011). The preference for western classification models such as the DSM-5 is evident in mental health research in Bangladesh. The preferred research methods chosen by most researchers are quantitative in nature, such as surveys based on a modified version of the Depression, Anxiety, and Stress Scale (DASS-21) to address the specific mental health issues in Bangladesh (Mamun et al., 2019; Banna et al., 2022; Hossain, 2014) and systemic reviews based on secondary literature. Out of the 20 articles chosen for this analysis, only three articles were written based on qualitative research (Koly et al., 2022; Islam et al., 2018; Akhter et al., 2017). The lack of qualitative data in mental health research in Bangladesh also indicates the lack of acknowledgement of the local epistemologies and etiologies of illness and suffering by neglecting the voices of the people as well as the interactive relationship between the healer and the patient (Summerfield, 2012) which is a key factor in building a stronger mental health infrastructure imperative to the global mental health movement (Kohrt & Griffith, 2015). Jakubec and Campbell (2003) explain,

> "When people engage competently with texts such as surveys and other data-collection tools, they use the resources of the text itself to determine how it is *intended* to be read. Thus informed, they are able to understand and follow the instructions as well as the unwritten rules. The practitioner's competency with the text's words and symbols makes possible the application of some of the text's meanings to the local setting" (p. 83)

In her organizational ethnographic research on the Pathway program initiated by the WHO to address the mental health needs in Gambia, Jakubec argues that there is an

authoritative connection between mental health surveys conducted in the Global South and the guidelines and protocols given by WHO (Jakubec and Campbell, 2003). The surveys and research designed following the WHO protocol influenced not only how the surveys will be conducted but also how they are to be interpreted by the researchers (Jakubec & Campbell, 2003). According to Jakubec, the survey questions on the Pathway Study by the WHO focused on collecting illness experiences of patients and categorizing them based on psychiatric and western ideas of treatment and causation, thus replacing any local etiologies, perception and practices related to illness (Jakubec & Campbell, 2003). Likewise, Comelles (2000) argues that modern biomedical models are not interested in understanding the local, political, and cultural contexts of diseases and are more inclined toward statistical and epidemiological assessments through health surveys (p. 42). The Pathway system implemented by WHO is designed to recognize psychiatric symptoms that take the focus away from the patient's narrative towards the need to assign diagnoses to symptoms. This not only puts local and traditional approaches in the background but also threatens to displace and discredit their values (Jakubec & Campbell, 2003; King, 2002). The Pathway system was also implemented in the National Mental Health Survey Report in Bangladesh. The survey was conducted in 2019 and the report was published in 2021. The survey was implemented by the National Mental Health Institution of Bangladesh with the support of the Noncommunicable Disease Control Program of the Health Ministry and with the collaboration of the WHOand the Bangladesh Bureau of Statistics. The objective of the survey was to explore the state of mental health in Bangladesh by assessing the prevalence of mental health disorders, the stigma towards mental illness, the treatment gaps and the attitude towards mental health

services. The survey also aimed to explore psychosocial and socio-demographic factors associated with psychiatric disorders in Bangladesh (Nation Mental Health Survey Report, 2021, p. 1). The survey used Self Reporting Questionnaire (SRQ) for adults and Reporting Questionnaire for Children (RQC) alongside socio-demographic and general mental health questionnaires for the household to gather data on the overall mental health situation in Bangladesh. The WHO developed both SRQ and RQC questionnaires to assess the mental health conditions in the Global South (Nation Mental Health Survey, 2021). Psychiatric researchers gave diagnoses following the DSM-5 (The Diagnostic and Statistical Manual 5), and the positive cases were selected based on the 'yes' and 'no' answers provided by participants from the SRQ and RQC. The National Mental Health Survey Report (2021) states that "…questions refer to some expressions of mental conditions such as, relationship with family members, insomnia, loss of appetite, lack of attention, unusual fear etc and some mental illnesses such as, depression, schizophrenia, obsessive compulsive disorder etc" (p.14).The survey questions looked for specific symptoms among the participants, such as lack of sleep, lack of appetite, fatigue, feelings of unhappiness, lack of motivation, uneasiness, paranoia etc. and assigned these symptoms to mental health conditions such as depression, anxiety, stress, bipolar disorder etc. (National Mental Health Survey Report, 2021). There are no mentions of any local etiology and explanations of illness and suffering nor any reflections on how people perceive, explain and experience illness in the local context. There is, rather, a tendency to remove or make invisible any other categories of illness in order to make the western and psychiatric model more visible as the only preferred method of healthcare in

Bangladesh. While exploring the implicit cultural dominance of the WHO study survey, Jakubec and Campbell (2003) explained,

> "The questionnaire served as a template for our interactions, with the nurses interviewing people in order to get specific answers and interpreting their comments in terms of the survey categories. With the increased emphasis on diagnosis came an increased emphasis on "appropriate" treatment — that is, Western psychiatric treatment" (p. 82)

This sentiment was mimicked in the National Mental Health Survey Report (2021) conducted in Bangladesh by asserting stigma as one of the main obstacles to treatment gaps and local faith healing as unnecessary.

> "High prevalence of stigma in relation with mental disorders in the society leads the patients to undergo unnecessary treatment by faith and traditional healers before seeking professional help" (p. 55)

The inherent hegemony of using western psychiatric treatments in the Global South is apparent through the labelling of traditional and local healing practices as ineffective and seeing them as instruments of delaying proper care (Jakubec & Campbell, 2003). The delay in receiving proper psychiatric treatment signals a lack of infrastructure that can meet "the burden of disease" sentiment. The argument for the epidemic nature of this global burden is tied to the idea of the loss of productivity among the population, which is seen as a great threat to society globally (Beneduce, 2019; Rose, 2019; Jakubec & Campbell, 2003). The emphasis on mental health interventions has a strong economic payoff as "this reliance on Western science to diagnose a condition and prescribe the most "effective" or "helpful" treatment sits in contradiction to the lack of medical

resources in many developing countries — potentially, however, creating new markets for Western corporations" (p. 85)

Critics of the mental health movement warn against the influence of pharmaceutical companies on shaping mental health interventions globally. Summerfield (2012) pointed out how big pharma in both the Global North and the Global South train both psychiatrists and healthcare professionals through data and research that helps to sell their drugs. The oversaturation of drugs among the poor in both India and Bangladesh has been noted by both Das (2015) and Callan (2012), respectively. The researchers have explored the reliance on biomedical drugs without proper diagnosis is rampant in both countries. Most people use old prescriptions to buy medication from local pharmacies that are often run by untrained shopkeepers working as local "doctors" who have no background in biomedicine. Jakubec, in her research in Gambia, noted the continued prescribing of medication by mental health care workers without any sustainable infrastructure in place (Jakubec & Campbell, 2003). The ground for GMHinterventions in the Global South is set by the underpinning discourses of development that focus on combating economic loss caused by mental illness through efficient and effective treatment (Jakubec & Campbell, 2003). Donor organizations such as WHO and World Bank determine how these interventions will be implemented, and the countries in the Global South use this as an opportunity to receive funding for necessary infrastructures. As explained in the National Mental Health Survey Report (2021) of Bangladesh, the main goal of providing better healthcare services is to meet the Sustainable Development Goals (SDGs). As Jakubec & Campbell (2003) put it,

> "Development is guided and supported by aid and lending agencies that, while "helping," also have a distinct view of how such development should proceed. All of these activities, and their textual representations, I suggest, are the basis of a new form of colonization through development, international aid, and tied trade" (p. 86)

The knowledge generated by organizations such as WHO through their documents and surveys shapes the way mental health services are structured in the Global South. But this process is often not beneficial to the countries they are designed to help (Jakucec & Campbell, 2003, p. 76).

Another way the GMHMasserts itself as the center of the mental health discourse is by normalizing the idea of a global crisis through pathologizing everyday experiences of personhood and sufferings as brain disorders and amplifying the quantification of categories of disorders affecting the global world (Summerfield, 2012; Rose, 2019). This idea of a global burden of disease further legitimizes the need to develop services and research dedicated to building a disease model that can combat psychiatric disorders under different socio-cultural and economic settings globally. This message is deeply ingrained in how most researchers perceive how health and illness should be mandated in Bangladesh. The tendency here is to find a balance between the neurobiological causation of the illness with the sociocultural outcomes and interventions to combat the mental health crisis in Bangladesh. Karim and Shaikh (2021) report that the Mental Health Act (2018) of Bangladesh defines mental disorders as "as conditions, including mental disability, drug addiction and any other clinically recognized mental conditions, that, being connected with a person's body and/or mind, hinder their normal living (p. 86)" and mental illness as "a form of mental illness other than mental disability or drug

addiction (p. 86)". A home survey conducted in 2007 in three different villages in Bangladesh found "the overall prevalence of psychiatric disorders in this rural area was 16.5%. Depressive disorders and anxiety disorders constituted about one-half and one-third of the total cases, respectively. A significantly higher prevalence of mental disorders was found among the economically poor respondents, those over 45 years of age, and women from large families" (Nahar et al., 2014, p. 44).

The process of mental health research in Bangladesh starts with identifying the intensity of the illness through statistical data mostly gained through different WHO reports published in Bangladesh, then tracing the underlying socio-economic and cultural discourses provided through western theorization of mental health in other Global South countries and referring to levels of measuring the mental health conditions among the sample population through systems like DASS-21 (Mamun et al., 2019; Chowdhury et al., 2021). The Depression, Anxiety, and Stress Scale is a way to quantify and categorically measure clinical diagnosis among patients. Researchers in Bangladesh are using this tool to identify the diagnosis of participants based on survey questions (Mamun et al., 2019; Chowdhury et al., 2021). The quantification of the different categories of mental disorders helps to solidify the idea of urgency and crisis.

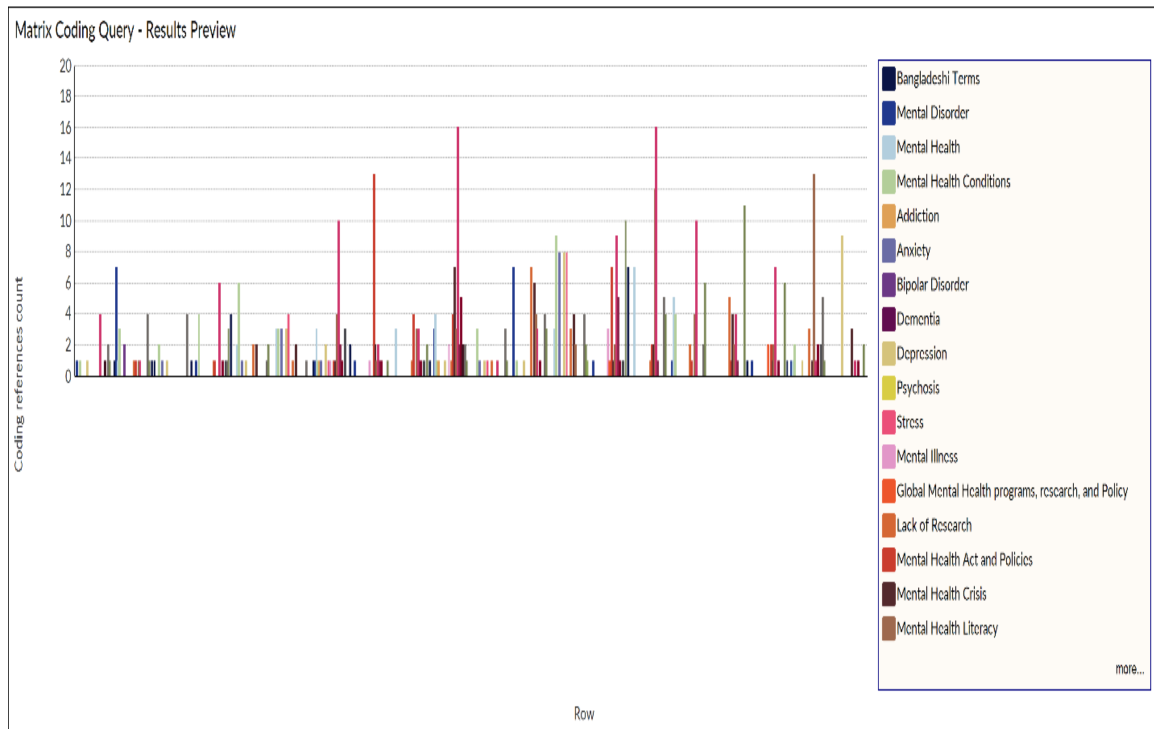


Figure 2: Data summary of the highest and the lowest uses of coded words and themes

The above chart shows the dominance of certain concepts used in the selected articles and the WHO and government reports. The highest coded word in the dataset is "mental health" services which have been coded 94 times. The lowest coded theme is Bangladeshi terms which include local terminologies of illness experiences, or local explanations of symptoms, as most illnesses are named after their symptoms. The rest of the themes cover different mental health conditions which were all categorized by psychiatric disorders such as anxiety, stress, depression, bipolar disorder, and psychotropic medications. As Summerfield (2012) pointed out, the use of western psychiatric categories of disorders are often treated as a possible equivalent of the local etiologies of illness in GMH interventions. This assumption puts mental health categories outside their social and cultural contexts. Summerfield (2012) argues that the validity and the

versatility of western categories of mental health cannot be taken entirely at face value. He states,

“In fact psychiatry has no answer to the question ‘‘what is a mental disorder?’’, and instead exalts a way of working it has devised: if there are sufficient phenomena at sufficient threshold, a mental disorder is declared to exist! This is as much alchemy as science” (Summerfield, 2012, p. 1)

The frequency of the codes also reflects the tendency among researchers to different rising and lowering of numbers of mental disorders among the population in Bangladesh over the last decade. The codes assert the importance of understanding the mental health scenario in Bangladesh by recording the prevalence of disorders among the population to look for gaps in the services that can benefit from GMHintervention.  As one of the chosen articles by Nahar et al. (2014) points out:

> An estimated 25% people suffer from mental health disorders worldwide. Almost 7 million people in Bangladesh experience depressive and anxiety disorders respectively…An estimate of 10,167 committed suicide in 2012, and suicide attempts were considered by 4% of boys and 6% of girls by youths aged 13–17 years (World Health Organization, 2020). In Bangladesh, the levels of depression, anxiety, and stress has been reported to be as high as 54.3%, 64.8%, and 59.0%, respectively"….Factors such as lack of awareness, stigma, government apathy, inadequacy in health systems infrastructure, limited policy considerations, and shortages of MH professionals contribute to these gaps in the MH care system…With that, the burden of mental illness is also expected to increase in the country. There are therefore strong grounds to mainstream mental health issues into disaster response in a more comprehensive fashion" (Nahar et al., 2014)

These materials affirm the rising numbers of identified cases of mental disorders. They further seek to establish the importance of amplifying the GMHdiscourse by introducing and re-introducing biomedical models of illness narratives among the population through the global and local levels of research. As Rose (2019) explains, the process through which quantification of the mental health burden leads to the legitimization of global mental health interventions around the world.

> "The quantification of the burden of 'living with disease generated grids of epidemiological visibility through which these brain disorders gained a new-found prominence in developed countries, underpinning demands for increased political action and funding for research. But in addition, estimates of the burden in low- and middle-income countries, as in the regular WHO reports, formed a crucial rhetorical underpinning for those seeking to promote intervention on mental disorders in those regions" (p. 37).

This reflects the arguments made above by Nahar and team (2014), where the authors justify the need for western mental health interventions due to the rising mental health burden in Bangladesh. They also highlight the lack of infrastructure to handle the rising numbers of mental health issues among the population. The use of the psychiatric model for measuring the prevalence of disorders among the population ignores multiple problems of translation and reliability of the "factual data" gathered through quantitative research methods. Summerfield (2012) states that the use of quantitative research methods in non-western countries to generate data on western mental health categories creates unreliable sources of information. As it lacks the ability to create knowledge about the cultural contexts within which people's sense of illness, health, and suffering emerge. There is an overarching notion of a lack of understanding and awareness of mental health among the locals in need of global interventions. As though people do not

have the capacity to understand their own sufferings, and only the experts versed in the western categories of mental health have the power to save them. The narrative of a lack of mental health literacy is strongly tied to cultural and traditional beliefs, which are often seen as backdated and as obstacles (Summerfield, 2012). It also ties to the notions of the need to develop better literacy and awareness through training, education, and better infrastructures. This is evident in the data as most of the articles (16 out of 20) pointed out the lack of healthcare workers and psychiatrists, and mental health hospitals in the country. One outcome of the terminology is the reification of the concept of “mental health” and yet the relative paucity of infrastructure and trained specialists, as is pointed out below.

As noted in the quotes below from Uddin et al. (2019) and Karim and Shaikh (2021), while the concept of ‘mental health’ dominates as a problem, there are relatively few specialists to provide treatment.

> "Bangladesh is the sixth most populous country in the world with approximately 50, 000 medical doctors for 160 million people. Among the medical doctors, less than 1% (500) are psychiatrists, indicating less than 1 psychiatrist per 300,000 people to provide specialized treatment. This ratio is much lower compared to 126 psychiatrists in Switzerland, and 44 psychiatrists in the United States. For inpatient care, Bangladesh only has one dedicated mental health hospital, and 50 psychiatric units in general hospitals. Such resources are insufficient to provide service for the large population in Bangladesh" (Uddin et al., 2019, p. 9)

> "Mental health problems are almost ignored in Bangladesh, one of the most densely populated countries in the world. The lack of overall health literacy and human resources due to an ineffectively updated legal and regulatory framework, coupled with very limited but misused budget allocation, are some of the factors responsible for this" (Karim and Shaikh, 2021, p.85)

The consensus is to build better mental health services and outcomes by increasing the mental health literacy rate through training of the healthcare workforce in Bangladesh. Equally, there is a call for a new model of healthcare, as Hasan et al. (2021) point out.

> "Mental health education should be re-evaluated and a newmodel of healthcare that incorporates the biopsychosocial model of care should be developed and taught in healthcare education programmes. This will build capacity by enabling future healthcare professionals to gain leadership positions and improve training programmes. Operational research should be the priority for mental health service development" (Hasan et al., 2021, p. 83)

One of the most significant obstacles to mental health literacy is seen as the cultural stigma associated with mental illness in Bangladesh. Researchers have pointed out that stigma, coupled with a lack of initiative and indifference from the government towards the growing concern over mental health, as well as the inadequacy of the available services, make pathways to treatment highly complex and difficult to navigate (Nahar et al., 2014; Uddin et al., 2019; Islam and Biswas, 2015). This results in barring people from getting proper treatment to get better and intensifies the violence against people suffering from mental illness in Bangladesh (Islam et al., 2018). Researchers place a strong emphasis on stigma and misinformation due to traditional healing and belief systems as a severe cause of distress among people suffering from mental illness in Bangladesh (Islam and Biswas, 2015). According to Nahar et al. (2011), mentally ill people are seen as a burden by society and their families and are subjected to cruel treatment, such as beatings and verbal abuse as a method of treatment (2011, p.45). Islam and Biswas (2015) point out that mental illness is perceived as a sin inherited from someone's parents, something carried through birth, or a result of spirit possession:

> "There is widespread stigma against people with mental illness in Bangladesh. There are many myths and superstitions surrounding the cause and outcome of mental illness. Mental disorders are primarily viewed as the result of being possessed by evil spirits rather than as illnesses that can be treated. Consequently, victims of mental illnesses are most often neglected, subjected to delayed care-seeking and abused" (2015, p.61)

Jakubec noticed in her research in Gambia that employing the WHO mandated surveys in data collection enhanced the local employees' perception of 'professionalism' and their attitudes towards the patients. The nurses preferred surveys over interviews as they appeared more efficient and time friendly. But this process also changed the relationship between the healthcare workers and the patient; as the author noted, patients were treated more as friends and family before (Jakubec & Campbell, 2003). In Bangladesh, an average psychiatric consultation can last no more than three minutes (Wilce, 2004), whereas the local healers have more knowledge about their patients' lives through relationships built over many years (Callan, 2012). The changes in attitudes of the health care workers can often lead to further stigmatization of vulnerable patients, further isolating them within their societies. Kohrt and Griffith (2015) explained that healthcare workers are often burdened or forced to take on roles as mental health service workers in the Global South due to a process of task sharing initiated by the government and protocols set by international organizations to expand mental health care services. The lack of existing infrastructure that can support psychiatric treatment prescribed by the GMHMfurther burdens the existing few healthcare providers leading to them further stigmatizing their patients (Kohrt & Griffith, 2015). Wilce (2008) echoed this statement in his study of psychiatric practices and their connection to madness in Bangladesh. He

noted that the power dynamics between the psychiatric practitioners and their patients were always uneven, with the former holding more weight than the latter. The National Mental Health Survey Report (2021) also noted similar obstacles in mental health practices in Bangladesh.

> “Primary health care service providers are not always well trained and sometimes not interested to provide mental health services. People with mental health problems also sometimes experience stigma within health care delivery system” (p. 49)

Establishing a balanced relationship where the patient feels respected and heard is the key to a successful healing process in mental health care (Kohrt & Griffith, 2015). By erasing the existing social relationships surrounding experiences of illness, mental health initiatives are distorting peoples’ experiences with their healthcare providers, which is the opposite of the requirement of psychiatric treatment practices.

This is affirmed more recently by Hasan et al. (2021) when noting:

> "While analysing the literature for this country profile, we have seen the widespread stigma surrounding mental illness prevalent across the country. Therefore, a strong advocacy plan is needed to educate the public through utilisation of mass media, setting-based approaches and peer education. The population should be educated about causation, which can be done through healthcare promotion activities in communities and through mass media… Public and professional awareness must increase in order to reduce stigma about mental disorders and discrimination among patients. Young advocates, including academics, media personalities." (Hasan et al., 2021, p. 84)

The work of Hasan et al. (2021) is significant because they affirm an ongoing attempt at replacing local epistemologies of illness and suffering while establishing a strong ground

for mental health research that solely follows the narratives and practices related to western psychiatric discourse.

The emphasis put on expanding the infrastructure of mental health services in Bangladesh borrows from the sentiments of a growing burden of disease and the need to meet the disparity in the gaps in services in the Global South. The path forward is to implement better service opportunities through training and task sharing among the local social health workers (Uddin et al., 2019; Kohrt & Griffith, 2015). The success of interventions relied heavily upon the incorporation and recognition of the existing health practices, with "interventions that did not confer an identity associated with the existing health system did not show positive outcomes" (Kohrt & Griffith, 2015, p. 585). The data, although meticulously collected and analyzed within the pages of the WHO reports and the journal articles, seem to completely ignore the realities and relationships between people and illness in Bangladesh. The insistence on the lack of services for mental health tries to sweep away the vibrant local and traditional practices that exist side by side with the biomedical services in the country (Wilce, 2004). Wilce also points out the tension between the transition of knowledge between different generations and the importance of navigating and negotiating multiple ideas of madness with the ideas of mental illness is crucial to establishing a good understanding of the changing mental health discourse in Bangladesh. Both Wilce (2004) and Callan (2012), who have conducted ethnographies in rural and urban landscapes of Bangladesh over many years, have shown that there are multiple pathways to treating mental health in Bangladesh. Most people follow multiple types of treatment based on availability and efficacy. Callan (2012), in her book *Patients and Agents: Mental Illness, Modernity, and Islam in Sylhet, Bangladesh,* explored the

experiences and choices of afflicted people through her encounters. She argued the flexibility and adaptability of traditional healers to incorporate biomedical explanations of local illnesses showed the complexity and nuances of people's experiences with illness and health in Bangladesh. My own ethnographic experiences in rural Bangladesh reflected Callan's (2012) arguments as my interlocutors, in many cases, looked for biomedical treatments like injections to heal spirit possessions (Farzana, 2017). The one-sided narrative of generating numbers and quantifiable data of mental health conditions and mental disorders without any local contexts takes away from peoples' voices and their active participation in their own lives. Instead of looking for binaries between biomedicine and folk medicine or biomedical model vs peoples' explanatory models (Das, 2015), looking through the complexities of the experiences, we have arrived through our unique and shared historical and political senses; we can build a better understanding of how illness and health shape our everyday lives. Looking at moments of interruptions and raptures as the driving force of peoples' lives only gives us fragmented ideas of how things ought to be. Illness is a shared experience carried through our memories that build up our resilience and approach toward healing (Das, 2015). The concept of shame is often identified as the main obstacle in getting mental health services in non-western communities by the researcher as a way to reinforce the colonized notion of backwardness of traditional values that do not align with the western values and unwillingness of patients to change their lives for the better. Milner et al. (2021) argue,

> "This prescribed notion of stigma needs to be contexualized within the cultural mistrust experienced by Asian American communities towards mental health systems. Such mistrust has several antecedents which include historical experiences of domination by colonial systems and structures, contemporary

> forms of racism and systemic oppression, and disconnection from traditional conceptualizations and methods of healing due to colonial erasure" (p. 335)

The concept of stigma presented by researchers studying mental health in Bangladesh (Nahar et al., 2011; Hossain et al., 2014; Nahar et al., 2014; Uddin et al., 2019; Islam and Biswas, 2015; Akhter et al., 2017; Islam et al., 2018; Mamun et al., 2019; Hasan et al., 2021; Karim and Shaikh, 2021; Arusha and Biswas, 2020) ignores that stigma is a shared experience that maintains the boundaries of social relationships. The stigmatization of mental illness has yielded various responses from people suffering from mental illness. In my ethnographic research in Bangladesh, I saw people perceived as "Pagol" (mad) maintain and navigate their relationships with others that did not confine them as purely helpless and subjugated to constant abuse. Through my interaction with families and neighbours of the afflicted, I was able to observe flexibility in how their relationships displaced love, respect, shame, neglect, and acknowledgement of their unique disposition that allowed them to be wiser than others (Farzana, 2017). People seen as mad could perform various roles within their social boundaries. *Pagol* (mad) women were often excluded from the social norm of mobility applied to other women in their society. They could move around freely in many dwellings ignoring existing gender norms but that did not mean that they gave up on being women within that society. There is a constant negotiation of pushing the boundaries of normativity and remaining within it that gets erased through the process of standardization and generalization of people experiences with illness and health, especially in the Global South.

## 3.2 The Erasure of Madness in Contemporary Mental Health Research in Bangladesh

Paglami and madness are as much an expression of illness as a sense of being. The universality of the western categories of mental health is unproven, and it forces us to promote a western way of understanding the self, which is not inclusive of how the rest of the world builds a sense of personhood (Summerfield, 2012; Horowitz, 2011; Beneduce, 2019). In Bangladesh, madness is not just the lack of normalcy; it is a cultural narrative on the illness perspectives of the people of the land (Callan. 2012). The erasure of madness in contemporary research in Bangladesh shows the belief that a universal understanding of mental health is attainable and desirable. Veena Das (2015) argues that there is no well-established epistemic understanding of why illness happens and that the practices kept by GMHinstitutions are as bewitching in their contradictions as any other models (p. 22).

| **General Term** | **# Of times used in the 2021 National Mental Health Survey Report** | **# Of times used in the 2015 Bangladesh Health Systems report** | **# Of times used in 2007 AIMS Report WHO Bangladesh** |
|---|---|---|---|
| **Disorder** | 617 | 15 | 21 |
| **Mental Disorder** | 996 | 94 | 230 |
| **Mental Illness** | 878 | 98 | 225 |
| **Mental Health** | 1199 | 1886 | 475 |
| **Mental Health Disorder** | 1435 | 1891 | 480 |
| **Mental Health conditions** | 1212 | 1889 | 475 |
| **Psychiatry** | 25 | 2 | 10 |
| **Psychiatrists** | 52 | 2 | 15 |
| **Psychotropic drugs** | 30 | 148 | 19 |
| **Community Health Service** | 582 | 2514 | 327 |
| **Traditional Healer** | 10 | 48 | 1 |
| **Traditional Healing** | 7 | 35 | 1 |
| **Folk Healer** | 3 | 15 | 0 |
| **Kabiraj (Folk healer)** | 0 | 1 | 0 |
| **General Term** | # Of times used in the 2019 National Mental Health Survey Report | # Of times used in the 2015 Bangladesh Health Systems report | # Of times used in 2007 AIMS Report WHO Bangladesh |
| **Mental Disease** | 793 | 235 | 230 |

| General Term | # Of times used in the 2021 National Mental Health Survey Report | # Of times used in the 2015 Bangladesh Health Systems report | # Of times used in 2007 AIMS Report WHO Bangladesh |
|---|---|---|---|
| **Faith healers** | 6 | 23 | 0 |
| **Homeopathic treatment** | 187 | 76 | 7 |
| **Mental Healthcare Workers** | 760 | 155 | 244 |
| **Mental Health System** | 1218 | 2042 | 489 |
| **Psychotic Disorder** | 244 | 5 | 11 |
| **Depressive Disorder** | 294 | 6 | 5 |
| **Depression** | 3 | 4 | 0 |
| **Bipolar Disorder** | 264 | 7 | 5 |
| **Anxiety Disorder** | 282 | 5 | 5 |
| **Stress Disorder** | 240 | 5 | 5 |
| **Madness** | 0 | 0 | 0 |
| **Mad** | 0 | 0 | 0 |
| **Pagol (Mad)** | 1 | 0 | 0 |
| ***Paglami* (Madness)** | 0 | 0 | 0 |
| **Manoshik Shastho (Mental Health)** | 0 | 0 | 0 |
| **Manoshik Oshukh (Mental Illness)** | 0 | 0 | 0 |
| **Spirit Possession** | 0 | 0 | 0 |

Table 1: Word counts for specific codes generated by NVivo

The table above shows the word count of the chosen codes within the one selected report from WHO and the mental health survey conducted by the government of Bangladesh in 2019, and a health systems report conducted by the leading research institutions in Bangladesh with the collaboration of the government. While the highest word count is "mental health system," the lowest is the term "Pagol," mentioned once in the mental health survey. There is no mention of any other local terms used to describe madness or mental illness in Bangladesh. The absence of the terms, such as Pagol and madness, can be associated with the attempt to bring a sense of physicality to the concept of illness through the term mental illness (Pinto, 2020). The psychiatric categorization of mental disorders can be seen as a way of narrowing down the vastness of concepts like Paglami and madness. The psychiatric practices promoted in Bangladesh evoke the perception of the local self under the gaze of a powerful other (Wilce, 2004, p. 357). The insistence on the removal of the local etiologies from the illness discourses is a way of modernizing the

"backward and harmful traditional practices" that are endorsed by the Bangladesh government to meet the international demand (Wilce, 2004) of GMH initiatives. The anxiety of psychiatric practitioners to establish themselves on the true scientific path stems from the idea that to be perceived as "scientific" boosts the validation of their work ", particularly in the context of international peer relations. In what appears to be an attempt to ward off the label "backward" for their national psychiatric profession" (Wilce, 2008, p. 93). Wilce (2008) argues this attempt at being recognized as a truly scientific endeavour encourages "Asian psychiatrists increasingly conform their labeling practices to cosmopolitan norms as embodied in the *DSM"* (p. 93). The relationship between psychiatrist and their patients are often fraught with tension as the patients are often berated and looked down upon by the practitioners for engaging with folk healers. As Wilce (2008) explains, "To have their compatriots speak of madness as *pa¯gala¯mi* 'craziness' (rather than *manarog* 'mental illness,' or *ma¯nasik rog*) – or even to hear that some of them fall prey to spirit possession – challenged the purity of the register that they struggled to establish" (p. 96). The push towards a global psychiatric modernism (Wilce, 2004) attempts to erase local etiologies in an effort to become antitraditional and progressive, which leads to the labelling of local terms as derogatory. The National Health Survey Report (2021) states, "in spite of advancement of knowledge about health people with mental health problems are still labeled with different derogatory terms by the media and public at large" (p. 55). The psychiatric colonialism of separating European madness from native madness (Ernst, 2010) is still carried through this way as we see there is little to no explanation of how the participants explain their illness narratives. Rather, more importance is given to the process of identifying and labelling

illness experiences under psychiatric and western categories of disorder in most of the recent research done on mental health in Bangladesh. The reports as well as the twenty articles chosen for this analysis, fail to explore the other illness narratives. Even though ethnographic research in Bangladesh has indicated an increase in preference for traditional and folk healing treatments by patients as a way to deal with the disappointment and disillusion of modernization (Callan, 2012). The erasure of native and local contexts and knowledge is a colonial and hegemonic practice often reinforced by mental health practices (Millner et al., 2021). Kohrt and Griffith (2015) state that we should pay attention to what kind of psychiatric knowledge holds power within different settings and who determines their power as we begin to understand the growing presence of a new kind of psychiatric discourse. Anthropologists have spent years looking at the shifting dynamics of power within the study of mental illness and have argued for various methodologies in ethnographies to address the complexities of the intersection of psychiatric models, cultural practices, and the global discourse of mental health (Lemelson and Tucker, 2015). Through her influential work, Linda Tuhiwai Smith (2021) traces the colonial legacy of research and the colonization of knowledge that continues to create barriers and restrictions towards indigenous peoples. Arguing that the west can claim, desire, and appropriate indigenous knowledge while simultaneously denying the people who create those knowledge and barring people from participating in the creation of their own knowledge and culture (2021, p. 1), Tuhiwai Smith provides potent strategies to decolonize methods, one being to critically assess concepts and practices of the “western archive” (2021:44). Likewise, Millner and others (2021) share how "mental health experiences of Asian American communities are characterized by disconnections

from ancestral culture and land due to colonization, alienation from culturally and spiritually grounded mental health practices, racial trauma, intersectional oppression, and systemic inequities" (P. 333). Researchers studying the commodification of ayurvedic practices through neo-colonization in the west explore how local knowledge can become products of wellness and spa culture through the global market economy, which later trickles down to the country of origin as an overpriced commodification of their own cultural practice (Islam, 2010). Edward Said (2019) saw the construction of "the orient" by the west through the holding of the power to authorize the description of the other through control and domination generated by different social institutions. “Research” is the amalgamation of the colonizers' desire to understand the colonized people through their (colonizers') perception and categorizations of the world (Tuhiwai Smith, 2021). As Bowker and Star (2000) point out, to classify and categorize is a human need, Tuhiwai Smith (2021) reflects how the European colonizers categorized and classified human beings alongside plants and animals. This disrespectful attempt at dehumanizing indigenous peoples further helped to establish the idea of indigenous communities as lesser human beings and incapable of a civilized way of life. Describing cultural practices and local epistemologies of illness as superstitious helped the British empire to establish western biomedical practices, especially in the case of madness (Mills, 2000). Labelling people's beliefs as superstitious help to erase their connection to their culture as well as their ability to create and distribute their knowledge systems. This can be seen in the articles analyzed in this chapter, such as, by associating the explanation of mental illness as a result of spirit possession as superstitious and harmful, the researchers tried to eradicate the peoples’ realities of the illness experience. Spirit possession can become

different mediums for expressing the roles the illness can play within a society. Spirit possession can allow people to borrow powers from saints to heal others, and it can also give a family a chance to share their illness experience. As the spirit travels from the body of the ill person to the rest of the family and creates a stronger bond through shared experience rather than isolation (Bellamy, 2011). Tuhiwai Smith (2021) argues that the colonization of knowledge played equal importance in controlling the world, and the relationship between imperialism, research and the production of knowledge should be understood and brought down to the colonized world (p. 68). She argued that we should pay close attention to how colonial disciplines have structured our way of knowing by educating the colonial elites and the "native" or colonized intellectuals (Tuhiwai Smith, 2021, p. 68). It is not hard to see how even researchers in the era of post-colonial and anti-colonial movements have clung to the practices and teaching of the colonial legacy. Therefore, it is imperative that the research in mental health in Bangladesh recognizes the pitfalls of continuing the colonial agenda in research and focuses on establishing avenues of knowledge that acknowledges the colonial shadow in our categorization of the world and find ways to collaborate on responsible research goals with the community and keep asking the questions of who, what, and why proposed by Tuhiwai Smith (2021). As in, who is this research for? What will it accomplish, and why should we participate in it? As Summerfield (2012) pointed out, the starting point of any research should be to understand how the localized knowledge surrounding mental health is being produced and maintained. The inclusion of ethnographic and anthropological research is crucial in building a flexible framework that considers the overarching socio-political and historical

contexts that are shaping peoples' sensibilities around their emotions and their grievances.

In this chapter, I have analyzed how mental health research in Bangladesh is being conducted through the framework of the global mental health movement. This pathway to ensure better healthcare and promote equity in mental healthcare in lower-middle-income countries like Bangladesh through a standardized psychiatric-biomedical model has neglected the illness narrative of the people in the country. While the researchers in Bangladesh advocate for evidence-based research in mental health, in reality, their work has resulted in reintroducing the hegemonic trope of the colonial legacy in research in the Global South. In this scheme of things, the Pagol becomes erased, local knowledge contorted and colonized.

# 4

# Conclusion

This concluding chapter reflects on the emerging themes from the intersection of the global mental health movement and contemporary research in mental health and illness in Bangladesh. Understanding the impact of the GMH agenda in a lower-middle-income country like Bangladesh is essential to encourage research that considers local systems of knowledge and ways to develop collaborative projects that aspire to alleviate peoples' suffering. The goal of this research is to break down the various complex mechanisms at play in the discourse of GMH from an anti-colonial perspective that emphasizes the decolonization of research methodologies in mental health research in Bangladesh. I have argued for the inclusion of madness as a method of decolonization for research in Bangladesh, as the idea of madness is intrinsically tied to the unique historical and political identity of how illness and suffering is perceived and lived within the community. It is imperative to include madness to theories and methodologies that try to encapsulate the complexities of standardizing initiative that advocates for removing disparities in care, especially in lower-middle income countries from a global perspective. In this thesis, I tried to show that the first step to improving the quality of research in mental health is to incorporate how people experience illness and health and their expectations and understanding of the various pathways to healing through more in-depth content analysis and analyses of policies and dominant paradigms governing approaches through hermeneutic analysis. At the same time, more in-depth qualitative

and ethnographic research is needed to understand the impact of dominant concepts at local levels. Conducting organizational ethnographies will help us to understand how international organizations like WHO shapes the local illness narratives. Ethnography is an excellent tool to intuitively situate oneself within the community to learn and expand one's knowledge of the nuanced cultural dynamics that encapsulate our everyday experiences. We can start by asking what 'mental health' can mean for us as Bangladeshis within our unique historical contexts. It is imperative to find ways to conduct research on an equal footing where we do not bypass local epistemologies as "traditional knowledge" that needs to be staged more palatably to fit the scientific discourses of psychiatry as a method of integration of cultural contexts. Traditional practices are not a representation of the past that exists within its own vacuum. These are the practices we have carried on from our longstanding negotiations with a hegemonic and colonial legacy in Bangladesh. Therefore, research should not just include the local terminologies of illness to be translated into psychiatric categories for the assessment of mental disorders. Mental health research in Bangladesh needs to acknowledge the existence and importance of local explanatory models and illness narratives while establishing pathways for treatment and healing, which are the amalgamation of multiple overlapping ideas surrounding what we mean when we talk about health, illness, and suffering. In these ways, we can move forward to decolonize mental health research in Bangladesh and beyond.

The GMHMis seen as medical imperialism as it separates and isolates people from their own knowledge systems and acts as gatekeepers and authorities in determining the mechanisms of how services, infrastructures, and policies related to mental health should

be created, designed, and distributed in lower-middle-income countries (Kohrt & Griffith, 2015; Millner et al., 2021; Summerfield, 2012). Critiques of the movement have pointed out that the use of psychiatric diagnosis and categories do not translate cross-culturally, and biomedical interventions have very limited roles in explaining social determinants of illness (Kohrt & Griffith, 2015; Summerfield, 2012).

Veena Das (2015) echoes this statement as she explains that while poverty and gender norms are associated with higher rates of mental disorders in lower-middle-income countries in mental health research, this is further from reality. Although the concepts of illness, suffering, and health are socially situated and shaped by cultural beliefs and practices, there is a lot of misconception and misuse of cultural concepts while explaining mental health crises in GMHresearch (Kohrt & Griffith, 2015). This is evident in how research is being conducted in Bangladesh. As it follows the framework of theGMHM, the researchers seek to standardize mental disorders through numbers, and they assign half-baked theories of socio-cultural stressors for mental disorders that fail to account for much of the illness narratives and practices regarding madness and illness in Bangladesh. As, despite the common use of the term "Pagol" (mad) by the locals, the researchers fail to mention any local etiologies and explanations of illness other than to describe them as superstitious (Islam & Biswas, 2015; Nahar et al., 2011). The evidence-based research acclaimed by global mental health initiatives often lacks the tools and tolerance to allow for multiple overlapping practices regarding illness. Collaborative research under this framework performs as a one-sided effort to train the locals in their psycho-biomedical models. Traditional healers and spiritual leaders within the community are assigned as potential mediators by WHO protocols and programs to influence the local perspectives

surrounding mental health (AIMS WHO Report, 2007; Faruk & Hasan, 2022; Alam et al., 2021). The power dynamic presented here begs us to question, who really is in charge? Who determines what disorder is and how the knowledge should be produced, and policies implemented? (Kohrt & Griffith, 2015). The questions are parallel to what decolonizing methodologists are asking us to do. To ask the important questions that highlight the tropes of colonialism within our academic understanding of how the other is constantly being produced (Tuhiwai Smith, 2021). True collaborative research should take into account the perspectives of the culture and people being explored. At the same time, developing standards and policies surrounding mental health, people's conceptions and ideas about how they suffer and how they see illness should be at the forefront. Mental illness is not just a disorder, a disease that only requires the practitioner's expert opinions. It is a shared experience that is intertwined in the complex web of our lives as social beings. As Veena Das (2015) points out, "the subject of illness or madness is not simply the individual but the web of relations (p. 205)".

The aim of this research is not to dismiss the importance of a shared belief in taking care of people through acts and policies that advocate for better infrastructure and health services. People are constantly suffering, and through research, we aim to locate better pathways to alleviate suffering. The goal here is to remind ourselves that such vessels of power structures in global politics which dictates the role of global health practices (Summerfield, 2012), determine not just the kind of services that should be developed and policies implemented; but who should be allowed to receive them. The solution is not simple, but I believe taking the right step toward building a better understanding of how knowledge is produced, influenced, and generated starts with how we research mental

health. Collaborative research projects that take into account local contexts and etiologies and acknowledge the role western psycho-biomedical categories play in perpetuating colonial tactics can help to better understand how research should be conducted and who should benefit from it. As pointed out by Star and Griesemer (1989) in their depiction of "boundary objects" instead of gatekeeping knowledge, the problem of translatability of diverging viewpoints should give the actors the ability to debate, negotiate, triangulate, and simplify to come to a standard agreement. The standardization should be flexible enough to respect peoples' various views while robust and consistent enough to allow a simplified idea that can be translated into multiple societal contexts. The idea proposed here is similar to how the GMHM depicts its role in bringing equity in care around the world through evidence-based local knowledge that complements the universal strategies implemented by the movement. The claimed flexibility is often discarded in the way as we tend to forget to negotiate and debate our roles, and our knowledge is being incorporated into the movement. In this way, the Pagol is erased, madness pathologized, and the minds of Bangladeshi people colonized.

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