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Transcult Psychiatry 0(0) 1–23 © The Author(s) 2019
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DOI: 10.1177/1363461518824433 journals.sagepub.com/home/tps
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transcultural psychiatry

Review Article

Challenges for implementing a global mental health agenda in Brazil: The "silencing" of culture

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Abstract
Since its emergence in 2007, Global Mental Health has been a growing and polemic area of study, research and practice in mental health worldwide. Despite having a significant endogenous academic production and innovative policy experiences, the Brazilian mental health field and its actors make few references to, and scarcely dialogue with, the Global Mental Health agenda. This article explores an aspect of this divergence between Global Mental Health initiatives and public mental health care in Brazil regarding the role of culture within mental health policies and practices. Our hypothesis is that part of this difficulty can be attributed to the low relevance of the cultural dimension for the Brazilian mental health field, here referred to as the "silencing of culture." We examine the possible historical roots of this process with reference to theories of "anthropophagy" and "cultural uniformity" in the context of Brazilian cultural matrices. We then describe two recent experiences in public mental health care that incorporate cultural competence through the work of community health workers and the example of community therapy. We argue that the development of cultural competence can be decisive in enabling an improved dialogue between research and practice in Brazilian mental health and global mental health initiatives.

Keywords
Brazil, community health workers, community therapy, cultural competence, cultural diversity, global mental health

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Introduction

In 2007, the first series on global mental health was published in *The Lancet* as part of a larger effort to highlight the global scale of mental health problems. The special issue urged international partners to join this "broad new social movement" to strengthen mental health (Horton, 2007). The authors argued that mental health has been largely neglected by the global health agendas and pointed to epidemiological estimates on the burden of mental disorders for families, communities, nations, and international economic systems (Prince et al., 2007). The series identified a major treatment gap between the need for and availability of mental health services and emphasized the individual and social costs of undiagnosed and untreated mental illness, in addition to the demand for effective and accessible interventions, especially in low- and middle-income countries (Patel & Prince, 2010).

However, the rise of the Movement for Global Mental Health (MGMH; http://www.globalmentalhealth.org), currently with some 10,000 individual members and 200 affiliated institutions, has lent new meaning to old controversies on the cultural universality or specificity of mental disorders and their symptoms. Critics have argued that the movement exports a Western model of illness and treatment, underrates the role of practitioners of traditional therapies, ignores cultural variability in appraising and responding to mental suffering, and medicalizes distress while ignoring its social and economic causes in low- and middle-income countries (Summerfield, 2012). Leaders of the MGMH refute such criticisms (summarized in Patel, 2014) on the grounds that the movement adheres to a concern for human rights and postcolonial openness to collaboration between the global South and the global North.

Meanwhile, proponents and critics of the MGMH agree on several points. Based on a version of "universalism", some researchers contend that, for pragmatic reasons, addressing a challenge of such magnitude requires adopting standardized intervention packages with a favorable cost–benefit ratio. An added rationale for this approach is that those standarized interventions are universally replicable and appear feasible and fundable to donors and governments. Other researchers counter-argue that effective interventions in diverse contexts cannot be developed in a standardized fashion using a database largely derived from research in developed countries, and that such interventions should be adapted to local cultural specificities, the characteristics of existing local health systems, and the particular needs of given population groups (summarized in Rose, 2018).

Few academic publications from Brazil enter into direct dialogue with the MGMH (Ortega & Wenceslau, 2015; Scivoletto, Filho, Stefanovics, & Rosenheck, 2014; Wenceslau & Ortega, 2015). An analysis of recent publications on public mental health care in Brazil (Ortega & Wenceslau, 2015) reveals a lack of dialogue between Brazilian academics, mental health professionals, and Global Mental Health (GMH) initiatives in two ways. First, issues pertaining to the Global Mental Health agenda, such as the expansion and qualification of mental health access through primary health care, have been the subject of policies,

although those policy guidelines and publications do not explicitly mention GMH as such (Wenceslau & Ortega, 2015). Second, there are relevant topics from this international debate that are actually less explored and get less visibility in Brazil, such as the subject of this article: the cultural aspects of mental health care practices in Brazil.

This article proposes to explore an aspect of this divergence between Global Mental Health initiatives and public mental health care in Brazil regarding the role of culture within mental health policies and practices. Our hypothesis is that part of this difficulty can be attributed to the low relevance of the cultural dimension for the Brazilian mental health field—a process we call the ''silencing of culture.'' We intend to examine the possible historical roots of this process, and explore this silencing of culture in recent examples of public mental health care that incorporate cultural competence. The development of cultural analyses in the context of Brazilian mental health may enrich our understanding of the complexity of the issues involving the care of mental health in global times.

"Cannibalism" and cultural uniformity: Obstacles for a multicultural approach to culture in Brazil

Most scholars in the field of cultural psychiatry assume the study of cultural aspects of large-scale mental health interventions as a central issue (Kirmayer & Swartz 2014). To deny access to diagnosis and treatment of mental disorders violates the human rights of persons with mental suffering, but to reduce the intervention to the replication of protocols and especially to the supply of medication also reproduces an approach that is negligent, harmful, and lacking evidence on mental disorders.

There is abundant evidence that culture contributes to structural inequalities and the distribution of health problems and resources in a population (Kirmayer & Swartz, 2014). Culture also influences cause, course and outcome of mental disorders, as well as explanations for mental distress. Beliefs and social norms also impact on individual and family coping, and adaptation to illness and recovery. Attention to these varied dimensions of culture can thus can greatly enhance the clinician–patient relationship, and provide tools to assist clinicians in the interpretation of symptoms that lead to appropriate and culturally meaningful interventions (Kirmayer & Swartz, 2014).

Our aim, thus, is to drawn on studies that objectively, subjectively, and qualitatively assess these interventions, for example involving community-based leaders, groups, and health workers and adaptation of protocols to specific local characteristics. Although Brazil boasts an important production of qualitative studies in mental health (L. G. S. Souza, Menandro, Couto, Schimith, & Lima, 2012), the analyses of cultural differences and cultural competence have so far not impacted the field in a relevant way. Cultural competence, i.e., the capacity of health professionals, practitioners, and services to significantly and effectively engage with patients' cultural backgrounds, values, and beliefs (Kirmayer, 2012a, 2012b), is an unfinished business for the Brazilian mental health network.

Brazil is a country of continental proportions with a single official language. In spite of a multiplicity of Indigenous languages (spoken by at least 100,000 people in a population of 210 million), a long history of migration, assimilation, and miscegenation, Brazil is generally portrayed as showcasing a homogeneous national cultural identity, which typically downplays racial, ethnic, gender, and religious diversity. This widely shared belief may also involve positive aspects. Perhaps one of the best notions for describing Brazilian cultural identity is Oswald de Andrade's (1928/1991) idea of *antropofagia* (anthropophagy/cannibalism) to characterize Brazilian modernism.

Oswald de Andrade and Mario de Andrade are considered the main intellectuals of Brazilian modernism. After the publication of the *Manifesto Pau Brasil* in 1924 Oswald de Andrade published the *Manifesto Antropofágico* in the *Revista Antropofágica* (1928)(Anthropophagic Review), a journal of art, poetry, and miscellany in which the main modernist writers presented their work. Echoing Andre Breton's *Surrealist Manifesto* (1924/1972) and influenced by Montaigne's essay on Brazilian cannibalism (1580/2003), Andrade's *Manifesto Antropofágico* inaugurated the anthropophagic movement in Brazil. The Manifesto encapsulates the ambivalent relation between European and Indigenous influences in Brazilian modernism. It proposed the ''devouring'' of cultural and artistic techniques imported from the developed world to turn them into export products. Anthropophagic primitivism appears as a sign of critical swallowing of the Other, the modern and civilized: ''Tupi,[1] or not tupi that is the question'', writes Andrade, ''I am only concerned with what is not mine. Law of man. Law of the cannibal'' (1928/1991, p. 38). In his utopian horizon, the patriarchal bourgeois system is replaced by the matriarchy of the primitive community: ''Down with the dressed and oppressive social reality registered by Freud – reality without complexes, without madness, without prostitutions and without penitentiaries, in the matriarchy of Pindorama'' (Andrade, 1928/1991, p. 44). Andrade imaginatively transforms Hamlet's formulation of the identity struggle into a postcolonial wrestle that refocuses an existential question in terms of local identity oscillating between the global and the tribal, between ''Shakespeare and the bush'' (Islam, 2011, p. 166).

The *movimento antropofagico* aimed to swallow (hence the metaphorical character of the word ''cannibalistic'') the culture of the ''external'' other (North American and European) and of the ''internal'' other—the culture of Indigenous peoples, of Brazilians of African descent, of European descent, and of Asian descent. In this view, foreign culture should not be denied, but it should also not be imitated (Andrade, 1928/1991). European modernism was digested while embracing indigenous cultural manifestations. In the 1960s anthropophagic ideas ware taken up by the *Tropicália* or *Tropicalismo* movement. *Tropicalismo* acted as ''efficacious divulgator'' of the anthropophagic perspective, as the singer and writer Caetano Veloso (1997) observes. *Tropicalismo* navigates between different cultural genres, such as the poetry of Augusto and Haroldo de Campos or Helio Oiticica's visual art (Adler Pereira, 2014; Islam, 2011; Ch. Perrone, 1990).

Depicted as the "most potent and durable metaphor in Brazilian culture" (cited in Islam, 2011, p. 159) to navigate cultural contradictions, anthropophagy has been widely used to address corporality, hybridity, and mixture within Brazilian culture. Postcolonial scholars have drawn on cannibalistic Brazilian modernism to analyze the "complex and paradoxical process of cultural appropriation in the 'South'", and claim a more general use of the anthropophagic metaphor in postcolonial thinking and as a complement to subaltern and orientalist approaches (Islam, 2011, p. 160).

Anthropophagy is thus a powerful metaphor to describe a Brazilian cultural identity that "swallows," appropriates, and levels-out racial, gender, or ethnic differences and incorporates them into its own national identity. However, the dismissal of cultural diversity does not result from some ideological distortion or cultural backwardness. Miscegenation is self-consciously affirmed as a form of social capital in Brazilian identity. Neglect of cultural difference, thus, is seen as a constitutive part of being Brazilian. Therefore, in Brazil, one does not speak of Italian-Brazilian, Japanese-Brazilian, or Syrian-Brazilian, despite the large numbers of descendants of immigrants from those countries. While the expressions "Afro-Brazilian" and "afrodescendant" have recently been used, they are largely restricted to academic and activist circles linked to the obligation of teaching Afro-Brazilian history and culture in Brazilian schools (Law n. 10.639-2003) and the introduction of affirmative action policies in the Brazilian higher education system (Silvério & Teodoro Trinidad, 2012). One cannot examine cultural issues in Brazil as if Brazilian cultural identity would follow the Anglo-American model of identity formation informed by multiculturalism and identity politics.

"Cultural uniformity", explains anthropologist Darcy Ribeiro (2000), is the most important consequence of the formation process of the Brazilian people as an ethnically homogeneous nation, a national ethnicity. According to Ribeiro, Brazil is a "unity-in-diversity" that integrates cultural, racial, ethnic, and regional differences. Unlike multi-ethnic societies ruled by unified states, "Brazilians integrate into a single national ethnic group, constituting one single people incorporated into a unified nation, an uni-ethnic State" (Ribeiro, 2000, p. 22). This, states Ribeiro, is why, in Brazil, despite the multiplicity of racial and ethnic origins of its population, there are no "quotas clearly opposed to the identification with the national macro-ethnicity" (p. 450).

Despite its cultural uniformity, Brazil is a deeply stratified society. Fundamental divisions are not those of culture and ethnicity of language, but those of class. That which "strays and separates Brazilians on opposite components is the class stratification" (Ribeiro, 2000, p. 450). Ribeiro is a harsh critic of class differences. For him, class distinctions "become so insurmountable that they obliterate all properly human communication between the masses and the privileged minority, which sees and ignores, treats and mistreats, exploits and deplores the masses as if this were a natural conduct" (Ribeiro, 2000, p. 24).

Several scholars have criticized Darcy Ribeiro's idealized view of Brazilian ethnic unity. They have stressed Brazil's multifaceted diversity of Indigenous

peoples and former slaves (the *quilombos*), as well as that of the believers in a multitude of religious denominations, and of people of Japanese and Arab descent, among others, which cannot be so easily subsumed by the Brazilian ethnic identity (Balee, 2003). There is also a ''religious war'' in Brazil involving Neopentecostals against Afro-Brazilian cults (including Candomblé, and Umbanda).[2] Moreover, the so-called ''myth of monolingualism'' hides the country's linguistic minorities, and discredits varieties of Portuguese which diverge from standard Portuguese taught in Brazilian schools (Bagno, 1999; G. M. Oliveira, 2000). The issue of miscegenation is the most contested matter, since some scholars see in Ribeiro's writings on race the reproduction of the ''most authoritarian standards of patriarchy and the ideology of whiteness'' (Nascimento, 2007, p. 56). More radically, Martinez-Echazábal writes,

> by ignoring the means of extreme violence and sadism with which, at times, the ''masters'' submitted women of ''inferior races,'' Darcy Ribeiro not only makes all Brazilians accomplices to a collective crime but also places himself in the counterstream of contemporary criticism. (cited in Nascimento, 2007, p. 60)

In short, with the words of Elisa Larkin Nascimento (2007, p. 60), ''white supremacy goes to bed with racial democracy. Their offspring is the hegemonic *moreno* of virtual whiteness.''

There is an ongoing debate around issues of racial democracy within Brazilian scholarship. One can mention, among others, the works of Fry (2000) and Moutinho (2004) that converge with Gilberto Freyre's (2003) classic thesis of harmonious miscegenation, while authors like Goldstein (2013) and Caldwell (2007), in agreement with Nascimento (2007), point to the persistence of racial-based inequities underlying class differences in Brazil. Thus, an extensive body of research seems to undermine the ideal of cultural and ethnic uniformity and stresses the presence of ethnic (Ramos, 2012), racial (Schwarz, 2014), gender (Giacomini, 2006; Kulick, 1997), and religious (Burdick, 1999) differences and their embodiment in modes of exclusion, segregation or social insertion, particular to the Brazilian context.

Our intention here is not to determine whether Darcy Ribeiro is right or wrong in his description of the formation of Brazilian identity as an ethnic unity. His book *O povo brasileiro* (The Brazilian people) does not result from empirical investigations. It is an essay, which, in the tradition of Sergio Buarque de Holanda (1995), Gilberto Freyre (2003), Paulo Prado (1997) and others, offers a general and totalizing interpretation of Brazil. Of course, many of the criticisms directed at his romanticized views are appropriate and have to be advanced, especially against idealized beliefs of Brazilian ''racial democracy'' that frequently underlie criticism of affirmative action policies for Black Brazilians in education and employment. Still, what is important for this article's argument is, first, that those cultural differences are not negated by Ribeiro; he simply says that they underlie (or are secondary to) the more fundamental difference, i.e., the class difference leading

to social discrimination and stratification; and, second, that the Brazilian Psychiatric Reform privileges class stratification and socioeconomic inequality at the expense of cultural diversity within the Brazilian population. Moreover, the sociocultural debates that have challenged the question of racial democracy until now have not informed the main theoretical and practical matrixes of Brazilian mental health care, the Psychosocial Care Paradigm and the Psychiatric Reform movement, as we will examine in the following section.

Culture and mental health in Brazil

Against this background of class stratification, the Brazilian Psychiatric Reform, which emerged in the context of the resistance to the military dictatorship and the following process of re-democratization,[3] has a distinctly political character. The reform depicts cultural differences as economic and social differences, i.e., as class differences. This central aspect is also present in psychiatric reform in Italy, which heavily influenced the Brazilian movement. Franco Basaglia, Franco Rotelli, and other professionals associated with the Italian Movement for Democratic Psychiatry (*Psichiatria Democratica*) denounced the social origin of psychiatric hospital inmates, who generally hailed from disadvantaged classes (Donnelly, 1992; Foot, 2015; Sforza Tarabochia, 2013). Hence, the expulsion and exclusion from society of psychiatric hospital inmates is, according to Franco Basaglia, more "closely linked to [their] lack of bargaining power (*pottere contrattuale*)—[their] social and economic status—than to the disease itself." It is because they are "socio-economically insignificant" that they are "pushed to the hospital walls" (Basaglia, 2014, p. 123). *Psichiatria Democratica*'s defense of the "lower classes" involves an explicit valorization of the class vector before other aspects of culture, which was transferred to the Brazilian reform. The latter exhibits a marked leftist libertarian spirit and privileges class relations and the "oppressed" (which includes psychiatric patients) (Amarante, 2000; Rotelli & Amarante, 1992). Again, if the Brazilian Psychiatric Reform took Marxist psychiatry seriously and did not exhibit the same enthusiasm for multicultural psychiatry, this has to do with the already-mentioned difference and singularity of the process of national identity constitution in Brazil.

The theoretical framework of the Brazilian psychiatry reform corresponds to the so-called Psychosocial Care Paradigm (Yasui, Luzio, & Amarante, 2016). Although frequently reduced to the shift of the mental health care services model from asylums to community mental health care—the Psychosocial Care Centers (CAPS, *Centros de Atenção Psicossocial*), psychosocial care is considered an epistemological turn in the mental health field. Human suffering is addressed in its complexity, as part of a psychosocial dynamics in which the labels of normality and sanity are suspended by exploring the social and biopolitical interests and mechanisms that produce those labels. Care is no longer understood as therapeutic isolation or moral treatment, but as "the creation of socialities and subjectivities" (Yasui, Luzio, & Amarante, 2016, p. 401). The patient—or the user, as the seeker of care is preferably designated in this

paradigm—is ''no longer an object of knowledge, but a subject expressing insanity'' (p. 401).

Brazilian psychiatric reform takes place on a trajectory, partly parallel, partly overlapping with that of the Brazilian health care reform (Fleury, 2011). The latter reached its culmination with the acknowledgment of health as ''a right of all and a duty of the State'' and the creation of a universal public health system, the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*) in the Constitution of 1988 (Paim, Travassos, Almeida, Bahia, & Macinko, 2011). The health care reform resulted from a significant social mobilization, frequently attributed to the Brazilian Sanitary Movement. Health care reform converges with several of the proposals of the Psychiatric Reform, especially the understanding of health care policies as promoters of democratic citizenship and the direct popular participation in their planning, evaluation, and management. Unfortunately, the same Constitution that establishes these principles also opens up a space for the participation of private health insurance companies in a ''complementary'' way to the public system. Although, on a constitutional and legal basis, Brazil has a universal public system, in practice, health financing in Brazil is mostly private due to the underfinancing of the public system and the lack of clear limits to the participation of private companies (A. Oliveira & Dallari, 2016). It is useful to point out that the universalization of the right to health in Brazil is linked to the defense of social rights as a central role of democratic states and, similar to the psychiatric reform, it did not significantly highlight issues related to ethnic or cultural diversity. Even though there are special health care policies for socially vulnerable populations in the SUS (e.g., black, indigenous, and LGBT populations; Souto, Sena, Pereira, & Santos, 2016), they occupy a marginal place, with a weak legal basis and minor financing support, contributing to worse health outcomes for these populations (Boccolini & Souza Junior, 2016; Coimbra et al, 2013; Glock, 2013; Nyarko, Lopez-Camelo, Castilla, & Wehby, 2013; Popadiuk, Oliveira, & Signorelli, 2017; Werneck, 2016).

Despite the downplaying of cultural diversity within Brazilian mental health services and practices, there has been, since the 1980s, an ongoing problematization and concern with the mental distress of the ''lower classes'' and the social and cultural differences between professionals and users, the latter largely of a lower socioeconomic status. The debate around the social and cultural differences between professionals and service users basically orbited around the notion of the ''*nervoso*.'' ''Doença dos nervos'' was considered the most common cultural idiom of distress among the Brazilian lower classes. It emphasized social and cultural dimensions of mental suffering: a physical vehicle for physical and moral experiences opposing biomedical understanding of distress as having a single cause (J. F. Costa, 1987, 1989; Duarte, 1988).[4] Thus, for instance, women from a rural settlement in Rio Grande do Norte addressed their mental and physical suffering in the idiom of *nervos*, which was theorized by scholars to be caused mainly by poverty, marriage, work overload, and domestic and sexual violence (M. Costa, Dimenstein, & Leite, 2014).

What J. F. Costa and others argued in the 1980s was that the expression of mental distress articulated through the idiom of the *doença de nervos* defied usual psychologists' and psychoanalysts' assumptions that located suffering within the individual subject, at the level of her feelings, desires, and thoughts. In the *doença de nervos* idiom, mental suffering and distress were described as being located in the body, the main vehicle of expression and communication of experiences. When psychologists and psychoanalysts introduced their techniques and theories to deal with the mental suffering of the ''lower classes'', they frequently assumed that this population shared the same world view, similar representations of health, disease, corporeality, and the same notion of personhood underlying their actions, values, and beliefs. As a consequence, social problems tended to be psychologized, leaving aside the sociocultural, historical, and political determinants of their behavior (Dimenstein, 2000; Lima & Oliveira Nunes, 2006). This way of managing psychological and psychoanalytical approaches to mental suffering was very much an expression of the clinical training in university clinics and psychoanalytic societies, and reflected a center of gravity in private clinical practice with no links with the public health system. Over time, the presence of generations of psychologists and psychoanalysts trained in graduate research centers where dogmatic teaching came under criticism informed by historical and sociological approaches to subjectivity began to change this landscape. Group psychotherapy and the notion of a *clinica ampliada* (expanded clinic) (Campos, 2003; Figueiredo, Libério, Gomes, Albuquerque, 1999) were proposed to deal with marginalized populations, and to a certain extent they still inform Psychosocial Care Centers (CAPS, *Centros de Atenção Psicossocial*) and Family Health Strategy interventions (Ferreira Neto & Kind, 2011).

The "silencing" of culture

Notwithstanding this intense problematization of the mental suffering of the ''lower classes'' since the 1980s and 1990s, the significance of ''cultural differences'' for causes, courses, and outcomes as well as cultural explanations for mental distress were incorporated neither into official documents and mental health policies, nor into the everyday practice of most mental health practitioners in the country. Thus, Lima and Oliveira Nunes complain of the

> inadequacy of the psychological techniques for a part of the population seeking health services, due to the psychological structure of the users, the unusual expressions of suffering, the socioeconomic conditions of the population, and especially the users' distance from an intimate and introspective style to express emotions and feelings. (Lima & Oliveira Nunes, 2006, p. 300)

In this framework, cultural diversity is frequently negated, naturalized or relativized. The ''silencing of culture'' (Oliveira Nunes, 2009, p. 39) within mental health services and practices can take place through the ignorance or misrecognition of

the cultural dimension within mental health practices and interventions, through its rejection when it involves conflict between world-views or sociocultural backgrounds, or through its reification and even caricature. This silencing is underpinned by frequent contempt toward popular beliefs and culture, which are regarded as obscurantist, rough, and less sophisticated (Oliveira Nunes, 2009, p. 44).

The most obvious example of this ''silencing'' is the issue of religious beliefs and practices and their role within mental health services and interventions.[5] From an academic point of view, there is still very little research being conducted on religion and mental health in Brazil and, a broader lack of consistent articulations between empirical data and theoretical analysis (Dalgalarrondo, 2007). Despite the scarcity of studies, the significance of religious practices as therapeutic agency among Brazilian urban ''lower classes'' has been acknowledged in the literature (Rabelo, 1993). An ethnographic study in São Paulo pointed out that religious idioms (including Catholicism, Pentecostalism, Candomblé, and Umbanda) provide young people diagnosed with psychosis with ways to elaborate and communicate their experiences, offering them ''resting points'' to deal with such overwhelming and perturbing conditions, as well as comfort and relief to their families (Redko, 2003, 2004).

In spite of these findings from the Brazilian literature and the presence of religious beliefs and practices within mental health services such as Psychosocial Care Centers, mental health professionals tend to adopt reductionist views of the relationship between religious beliefs and behaviors and mental distress and often disregard users' religious experience as significant to the cause, course, and outcome of their distress (Lima & Oliveira Nunes, 2006; Oliveira Nunes, 2009). The symbolic and cultural dimension of religious experiences (and more specifically Pentecostalism) of mental health services users is frequently ''overlooked'' or even ''negativized'' by professionals (Silveira & Oliveira Nunes, 2013, p. 130).

At a more general level, mental health professionals report the necessity of cultural adaptation (and more specifically, language adaptation) to deal with users from the lower classes, given their scarce symbolic and communicative resources. The underlying sociopolitical and cultural issues are seldom addressed. Professionals implicitly reveal their prejudices when dealing with that population. (Rosa & Campos, 2013).

On the other hand, individuals from the ''lower classes'' find alternative ways to deal with their mental distress in Pentecostal churches and Umbanda centers or in an array of alternative therapeutic services following different cultural systems diverging from the hegemonic treatments within public mental health services. These therapeutic alternatives, such as the ones found in religious associations, are more attuned to their notions of personhood and ways to alleviate the manifestations of suffering and distress. ''Religious services – catholic, spiritist, afro-Brazilian and other – act as true existential intensive care units'', writes Adalberto Barreto, psychiatrist and founder of Brazilian Community Therapy. ''Here culture tries to provide support where institutions failed'' (Barreto, 2010, p. 23). From this

perspective, to assume that the therapeutic tools offered in health services would be the only ones to provide some relief and effectiveness would be an attitude "not only naive but deeply ethnocentric" (Fonseca, 2009, p. 474).

Addressing cultural competence in Brazilian mental health care

In the last part of this article, we discuss two experiences of cultural competence and sensitization that take into account the diversity of symbolic and therapeutic systems, as well as conceptions of mental suffering of Brazilian mental health users: the role of the community health workers (ACS, *agentes comunitários de saúde*) and the Community Therapy (TC, *terapia comunitária* or *terapia comunitaria integrativa*). These two examples describe common experiences of primary mental health care within the Brazilian Family Health Strategy. Both valorize local culture and resources and favor the constitution and strengthening of local support networks.

Within the Brazilian public health system, primary mental health care is part of the primary care services offered by the Family Health Strategy (ESF, *Estratégia Saúde da Família*), the primary health care model adopted by the SUS (Ministério da Saúde, 2003, 2011, 2012). Brazilian policies follow the World Health Organization recommendations to integrate mental health in primary care at a global scale (WHO & WONCA, 2008). However, this integration lacks clear policies in Brazil that may establish the different roles of ESF, Matrix Support Teams[6] (NASF, *Núcleos de Apoio à Sáude da Família*), specialized mental health outpatient services (secondary care), and Psychosocial Care Centers in the assistance of people with mental health problems (Athié et al., 2016; Wenceslau & Ortega, 2015).

Community health workers

Community health workers have a leading role within the Family Health Strategy (Ministério da Saúde, 2012). The ACS should enable the interaction between ESF teams and communities, and must live in the territory they assist. Each community worker is responsible for up to 750 people living in their territory and each ESF team has a maximum of 12 workers. They carry out regular home visits, monitor health indicators, and develop health promotion and disease prevention, mainly through educational initiatives. As of September 2016, the ACS had attended to more than 129 million people, almost 67% of the Brazilian population.[7]

One of community health workers' main tasks is to implement actions aiming at integrating ESF teams and the community. They assume the role of mediators between, on the one hand, local cultural idioms and lifestyles and, on the other, scientific knowledge and the working process of the teams. This role makes the ACS a social actor who mobilizes contradictions and at the same time establishes a deep dialogue between these two world-views (Oliveira Nunes, Trad, Almeida, Homem, & Melo, 2002). As they are members of the communities, local cultural values and habits are embodied by the ACS, who have the challenging assignment

of trying to conciliate them with the biomedical speech that they also come to represent (Lara, Brito, & Rezende, 2012).

The ACS know everyone they care for personally, where and how they live and the nature of their major health complaints and sometimes even their life preoccupations. Through home visits and health education groups, the ACS draw on their knowledge of the cultural idioms (in a broader sense, including poetry, music and other forms of art), customs, and local or private beliefs of the community to facilitate understanding and make sense of the guidance, life habit changes, and treatments offered by the family health teams. In addition, in regular team meetings, they convey information about individuals' and families' health to the main group of professionals who work within the units (doctors, nurses, and nursing technicians). Such guidance often demands some form of translation between biomedical and popular world-views, like understanding why some patients refuse biomedical treatments and favor instead a religious practice or traditional medicine (Lara et al., 2012; Paiva et al., 2016; I. C. Pereira & Oliveira, 2013). The ACS therefore exhibit important cultural competence that makes them indispensable actors effectively engaging with patients' and communities' cultural backgrounds, values, and beliefs.

However, this mediation role also leads to situations in which upholding this dual identity brings uncertainty and difficulties. This contradiction is visible in the conflicting results from several qualitative studies on the experience of the ACS in mental health care in Brazil. Some studies point out that the ACS have incorporated into their practice principles and strategic tools in line with the psychiatric reform and the expansion of mental health in primary care. In these studies, the ACS seem to build continuous and effective links with individuals and families who live with mental distress. They develop knowledge and practices consistent with the psychosocial care paradigm and with an expanded concept of health (Barros, Chagas, & Dias, 2009; G. A. Santos & Oliveira Nunes, 2014; J. Souza et al., 2015).

On the other hand, there are results that indicate that community workers have major difficulties in dealing with mental health issues. In these analyses, the ACS show prejudice regarding mental disorders and, although they recognize the importance of working with patients and their families, they do not feel prepared to provide adequate care (Moura & Silva, 2015; Waidman, Costa, & Paiano, 2012). The ACS were also shown to exhibit perceptions about mental distress in line with the traditional psychiatric paradigm (as opposed to the psychosocial care paradigm), which considers people with a mental illness as passive persons, without the necessary conditions to become the protagonist of their own history (M. Pereira, Barbieri, Paula, & Franco, 2007). In other investigations, ACS discourses reproduce folk views of mental health that are more focused on the "dis-order"—on the behavior's abnormality—than on distress, lacking understanding of a broader concept of mental health (Cabral & Albuquerque, 2015).

Recent studies have also addressed the mental health of community health workers. The prevalence of burnout syndrome ranged from 24.1% (A. T. C. Silva & Menezes, 2008) to 29.3%, (Almeida, Baptista, & Silva, 2016) in the studied

samples, while the prevalence of common mental disorders (depression, anxiety, and somatization) ranged from 43.3% (A. T. C. Silva & Menezes, 2008) to 48.6% (Knuth et al, 2015). These data suggest that community health workers are a population highly vulnerable to mental distress. These findings thus put into evidence another aspect of the conflicts involved in their mediator role for mental health care interventions: having the duty of supporting people with mental distress on the one hand and being part of a population that intensively demands this type of care on the other.

Community Therapy

Brazilian Community Therapy or Integrative Community Therapy was initiated in the 1990s by psychiatrist Adalberto Barreto in Fortaleza, Northeastern Brazil. Its theoretical basis is rooted in systems theory, communication theory, Paulo Freire's pedagogy, cultural anthropology, and resilience theories (Barreto, 2005).

Each Community Therapy (TC) session, also called *roda*, consists of six phases: welcoming, selecting a theme, contextualization, problematization, closing, and appreciation. Every stage has a specific progression and sequence of actions, leading participants to observe themselves through accounts of personal experiences (Barreto, 2005; Gonsalves, 2012). After the welcoming, in which the rules of TC are explained and some jokes or engaging exercises are introduced, one topic is chosen through a vote among the possible issues raised by the participants. During the contextualizing step, the person who proposed the topic is invited to give more details about her situation, emotions, what and who contributed to the problem, and what was done to overcome it. The entire group may ask questions in order to clarify some points.

Then, in the problematization phase, the facilitator asks who in the group had already experienced a similar situation and what did they do to overcome it. Problematization starts with the TC therapist's motto. This motto is nothing more than the key question addressed to the group for discussion. Everyone may become aware of the many possible outcomes and solutions, promoting resilience and self-esteem. The closing ritual and appreciation phases will consolidate links between participants and highlight what they have learnt from the group. The evaluation enables the facilitators to have a critical view on the session, and collect data for further research (Barreto, 2005; Gonsalves, 2012).

It is important to highlight that TC is not intended to be a form of psychotherapy, but is rather a social intervention addressed to the community; it is not a public therapy for an individual, but a form of community therapy emerging from a problem brought by an individual and chosen by the community to organize the discussion (Grandesso, 2010).

TC has demonstrated efficacy in mental health promotion within primary mental health care (Cezário et al., 2015), and helps mental health professionals to grasp the emotional conflicts within individuals, families, and community. It constitutes a privileged space to transmit social support, strengthen emotional

bonds, consolidate social networks, diminish social exclusion and stigma, and enhance individual and group resilience (Rocha, Pinto de Sá, Braga, Ferreira Filha, & Dias, 2013).

One of the main features of TC that is particularly relevant for the argument put forward in this article is respect for cultural diversity and the multiplicity of contexts and local knowledges and practices (Grandesso, 2010). This attention to diversity illustrates how cultural anthropology constitutes one of TC's epistemological frameworks. Community therapy valorizes the cultural heritage of Indigenous, African, Asian, and European ancestors as well as the knowledge emerging from the individual's life experience (D'Afonseca & Barbosa, 2013, p. 429). Therapists have to know the local culture where TC takes place, particularly during the contextualization and problematization phases (A. Santos, 2010). Moreover, TC mobilizes local cultural resources as integral to the whole session. Any participant can interrupt the speech to suggest a song, remember a saying, or make a joke related to the situation.

Cultural and ludic resources contribute to TC success, attracting people to take part in the *roda* and disinhibiting participants to express their suffering. Those resources strengthen community and social bonds and help participants reframe and resignify their suffering (D. Oliveira & Ferreira Filha, 2011). Cultural and ludic resources, such as songs, praying, sayings, popular games, and jokes, may help soften life stories strongly marked by feelings of suffering and exclusion. As one of TC's fundamental tools to embrace pain, music also stimulates resilience and resignification capacities and help provide a feeling of belonging and inclusion in the community. Traditional sayings are also mobilized, thus rescuing the community's cultural roots and enhancing the community's identity (D. Oliveira & Ferreira Filha, 2011, p. 528). Hence, community therapy manifests strong permeability to the community's cultural resources and incorporates them throughout the whole session.

TC constitutes an original example of cultural competence within primary mental health care. The approach bolsters community bonds, mobilizes experience, local and cultural competences, and respects each individual's cultural referents and the participants' own solutions to cope with their distress. Community therapy makes therapists and participants co-responsible in the transformation of suffering into occasions for personal growth, thereby enabling the formation of solidarity networks (Bittencourt, Borges, & Oliveira, 2010, p. 272).

All the literature we mentioned addresses TC as a useful, valuable, and culture-sensitive intervention without mentioning problems or unsuccessful experiences. Although empirical studies reaffirm its positive outcomes (Cezário et al., 2015), the literature lacks more critical and nuanced approaches to TC. This "only positive" evaluation does not correspond, for example, to the experience of one the authors of this article (LDW) who has worked in Brazilian ESF as a family physician. In his clinical work, many patients, especially in small communities, refuse to participate in TC and other group therapies out of a fear of being exposed to their neighbors, friends, relatives or coworkers. These difficulties and other unsuccessful aspects of TC should be addressed in further studies.

Conclusion

Developing strategies of cultural competence can assist mental health practitioners in the interpretation of symptoms in ways that can lead to appropriate and culturally meaningful interventions. Mental health interventions are more accessible, acceptable, and effective when they are culturally adapted. Patients can integrate cultural explanations to communicate their distress in intelligible and social meaningful ways. As Kirmayer and Swartz (2014) state, incorporating cultural dimensions into mental health has implications for research, training, and practice.

In this article, we examined the issue of culture within mental health care in Brazil. We presented the political and epistemological orientation of the psychiatric reform, which references the interpretations of "anthropophagy/cannibalism" and "cultural uniformity" of Brazilian cultural matrices, and is largely based on the recognition of and attention to class and economic inequalities as main determinants of mental illness. This orientation does not necessarily ignore, but relegates racial, ethnic, and religious issues to the background, at least when compared to the importance given to multiculturalism and cultural differences in the Global Mental Health debates. The latter usually focus on cultural adaptation of diagnostic and interventional tools (Patel, 2014) and seem to ignore how severe poverty and deep social inequalities pervade the lives of the majority of people in the "non-Western world" and are major determinants of their mental suffering (Bracken, Giller, & Summerfield, 2016).

Despite these challenges, we described recent experiences of mental health work in primary care, which we examined through the work of community health workers and community therapy. We argued that these experiences result in relevant, and not necessarily conflicting, exceptions to the "silencing" of culture within the Brazilian Psychiatric Reform. These community practices provide local paths for the insertion of cultural issues into mental health care in the Global South. We showed that these approaches, while not as focused on ethnic diversity as standard Global Mental Health approaches to culture, remain committed to addressing human life in its multiple dimensions.

To conclude, we propose to think of culture as a process that emerges through institutional and interpersonal interaction; a process that is "constantly remade through social encounters, ethical deliberations, political processes" (Biehl, Good, & Kleinman, 2007, p. 7). From this perspective, cultural analyses assume the task of exposing "the differences of interests, access, power, needs, desires, and philosophical perspectives" (p. 8) in which social and interpersonal relationships are immersed. In the Brazilian scenario, where the weight of issues of race, gender, class, hybridization, and reinvention of knowledge and behaviors are in broad movement on a scale of hundreds of millions of people, such an understanding can be critical in enabling an expansion of dialogue between the research and practice in Brazilian mental health and global mental health initiatives.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The Brazilian National Council for Scientific and Technological Development (CNPq) MCTI/CNPQ/Universal 14/2014. Project no 443137/2014-5.

Notes

1. The Tupi-Guarani language, a creole of various indigenous languages, was a *lingua franca* in Colonial Brazil, and spoken by educated and lay people alike.
2. Data compiled by the Commission for Combatting Religious Intolerance in Rio de Janeiro (CCIR) show that more than 70% of the 1014 cases of offenses, abuse, and violent acts recorded in the state between 2012 and 2015 are against practitioners of Afro-Brazilian religions. According to some scholars, there are two main reasons for this hostility. First, the presence of racism and discrimination that go back to slavery and colonial times and which dismiss such religions simply because of their African origin. Second, the action of Neopentecostal pastors and believers who, in recent years, have made use of myths and prejudice to "demonize" and inflate the persecution of Umbanda and Candomblé believers and practitioners (Puff, 2016; V. G. Silva, 2007). This situation certainly impacts the ways people suffering from mental illness and their families resort to different religions for help.
3. The key historical milestone in the Brazilian Psychiatric Reform is the Caracas Declaration (1990), which set up the guidelines for the shift in mental health care from a hospital-oriented system to primary health care, promoting alternative, community-centered treatment. Still, before that date, in the context of the redemocratization of the mid-1980s, mental health workers, together with trade unions and left-wing politicians, advanced the so-called "anti-asylum struggle" movement (*movimento de luta anti-manicomial*) in 1987 and criticized the psychiatry establishment's collaboration with the dictatorship. Also in 1989, the first Psychosocial Care Center (*Centro de Atenção Psicossocial* – CAPS) was created in São Paulo City and in the same year some psychiatric hospitals were closed down in São Paulo State. In 2001, the Psychiatric Reform Law (Federal Law 10.216) was approved, which guards the protection and rights of those with mental disorders and redirects the model of care in mental health. The Brazilian Mental Health Policy originates from this law. Under the Lula administration, the Psychiatric Reform gained new impetus with the document "Princípios Orientadores para o Desenvolvimento da Atenção em Saúde Mental nas Américas," which revalued the Caracas Declaration and the results obtained since 1990 (Hirdes, 2009).
4. Obviously *doença de nervos* is not a Brazilian phenomenon and is widely used in Spanish-speaking Latin America (*Nervios, Susto*, and *Ataques de Nervios)* as a *culture-bound syndrome (*Nogueira, Mari, & Razzouk, 2015). There is a debate whether "nervios" is better understood as culture-bound syndrome or as cultural idiom of distress or popular illness (Guarnaccia, 1993; Kirmayer, 2001).
5. There exists an important contradiction concerning the place that religious beliefs and movements occupy in mental health care in Brazil. As we argue in this article, strategies to promote respect and to integrate religious diversity into mental health care are weak and insufficient. However, a proselytist religious approach has gained substantial ground in recent years through the growing number of the so-called Religious Therapeutic

Communities (F. M. L. Ribeiro & Minayo, 2015). They are considered a distortional version of the original community therapies' proposal (P. A. K. Perrone, 2014) and are focused on the recovering and rehabilitation of drug users through spiritual treatment, financed or co-financed by religious organizations and the State. Although they represent a significant manifestation of religious movements in Brazil (and more specifically, of Neopentecostal movements), they are not an instance of mental health care initiatives concerned with cultural diversity preservation through culturally competent approaches. For that reason, they certainly do not constitute an exception to the silencing of culture that we address in this article and, at the same time, they violate many principles of the Psychiatric Reform.

6. Matrix support teams (NASF), i.e. the Brazilian model of collaborative care, are multidisciplinary teams composed of diverse health professionals (e.g., physical therapist, social worker, dietician), including one mental health professional (e.g., psychologist or psychiatrist). Each NASF team covers and offers specialized support to nine ESF teams, according to the population size. The NASF mental health professional works in order to improve the ESF teams' capacity to identify and address emotional suffering as well as following the mental health cases in the territory (Athié et al., 2016). The diversity, complexity, and networking problems of the public mental health services in the SUS are addressed by Athié et al. (2016) and Ortega and Wenceslau (2015).
7. Source: http://dab.saude.gov.br/portaldab/historico_cobertura_sf.php

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