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Examining Global Mental Health, Bio-Politics and Depression in Ethiopia: A Critical Ethnography Study.

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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Abstract

Depressive disorder stands as a significant global health challenge and recognized as the primary cause of disability worldwide. Collaborating with the World Health Organization (WHO), Global Mental Health (GMH) initiatives have devised tailored international guidelines and intervention programs for low- and middle-income countries (LMICs) in response to this crisis. Despite concerted efforts, depressive disorder often remains underdiagnosed and undertreated in LMICs. However, our global understanding of depression is predominantly based on Western nosology, potentially limiting its universality. Consequently, existing clinical research and practices may fail to capture culturally relevant and salient aspects of depression.

Utilizing qualitative ethnographic methods, including Foucauldian critical discourse and document analysis, in-depth interviews, field notes, and observations, the study explored the conception(s) of depression among diagnosed individuals and healthcare providers and its cultural shaping in Bahirdar City, Northern Ethiopia. Specifically, it aimed to understand how patients diagnosed with depression conceptualize their condition and whether these local conceptions align with international definitions outlined in DSM-5 (APA, 2013). Additionally, through (re) reading global mental health as a biopolitical discursive practice (Foucault, 2008), the dissertation examined how a specific body of knowledge about depression was constructed and circulated and reshaping the landscape for psychiatric subjects in LMICs (Ethiopia).

Thirty-five in-depth interviews, involving purposively selected patients with depression (n=20) and mental health care workers (n=15) from two major psychiatric units were conducted. Findings revealed that patients perceive depression as a complex syndrome with cognitive, emotional, and physical symptoms. They attribute its origins to psychosocial, economic, and spiritual factors, highlighting the inseparable link between the mental and the social. While many symptoms align with DSM-5 criteria, five frequently mentioned symptoms do not conform, highlighting limitations in global diagnostic paradigms. Healthcare providers describe challenges in defining, diagnosing, and treating depression within a cultural context influenced by local beliefs.

The biopolitical discursive analysis of GMH intervention guidelines revealed power dynamics, operate as part of knowledge-power processes, materializing in certain forms rather than others, and shaping mental health discourse. The analysis identified several resistive discourses and suggested reconceptualizing the treatment gap for common mental disorders. This dissertation contributes to global mental health systems promotion, stressing contextually grounded interventions in LMICs. By targeting social, cultural, and structural determinants of mental health(depression), policymakers and practitioners can work towards more equitable and effective mental health systems worldwide.

Key Words: Global Mental Health, Depression, Biopolitics, Ethiopia; “impaired life”, Cultural-ecosocial Approach, Ethnography

Summary for Lay Audience

Depression has emerged as a global public health concern, often remaining underdiagnosed and undertreated in low- and middle-income countries (LMICs). However, our current global understanding of depression is primarily rooted in Western nosology, which may not universally apply. Consequently, existing clinical research and practices may fail to capture culturally relevant and salient aspects of depression. This dissertation ethnographically explored depression among individuals who are diagnosed with depression and healthcare providers and its cultural shaping in Ethiopia. The study involved two main processes. First, it aimed to understand how patients diagnosed with depression conceptualize their condition. Second, it explored whether these local conceptions of depression align with the international definitions of depression outlined in the DSM-5 (APA, 2013) or ICD-11 (WHO, 2022). Ethnographic methods, including in-depth interviews, field notes, and observations were utilized. We conducted 35 in-depth interviews, involving purposively selected patients with depression (n=20) and mental health care workers (n=15) from two psychiatric units.

Findings reveal depression was often attributed to challenging life circumstances, with local social interactions shaping illness meanings, highlighting the inseparable link between the mental and the social. Spiritual explanations and traditional healing play a significant role in patients' accounts, and the decision to seek medical help was influenced by the severity of symptoms. While there was substantial overlap with DSM-5 diagnostic criteria, certain symptoms mentioned by patients did not align with those criteria, highlighting limitations in global diagnostic paradigms for Ethiopia and beyond. Improved screening, detection and diagnosis requires expanded understanding of local conceptualizations to facilitate interventions acceptable to those affected. Healthcare providers describe challenges in defining, diagnosing, and treating depression within a cultural context influenced by local beliefs. Addressing these complexities requires culturally informed interventions and enhanced screening processes. As we continue to strive for improved mental health on a global scale, it is imperative to elucidate the social context of mental health issues and identify the cultural and structural factors from which suffering arises. This understanding can guide the design of healthcare systems, improving access to care and facilitating the development of culturally relevant and effective intervention programs.

Co-Authorship Statement

I, Gojjam Limenih, acknowledge that this thesis includes four integrated manuscripts that evolved as a result of collaborative endeavors. In all four manuscripts, the primary intellectual contributions were made by the first author who: researched the methodology, designed the research, developed the ethics application, conducted the literature reviews, established relationships with participants, undertook data collection, coded the data, led the data analysis, and led the writing of the manuscripts. The contribution of the co-author, Dr. Elysee Nouvet (in chapters 5, 6, 7, and 8), was primarily through supervision of the research, theoretical and methodological guidance, reflexive dialogue, and intellectual and editorial support in crafting the work for publication.

The contribution of the co-authors, Dr Arlene MacDougall, and Dr. Marnie Wedlake (in chapters 5) and Dr Arlene MacDougall and Maxwell Smith (in chapters 6, 7 and 8), was primarily through methodological guidance, and editorial support of the first draft of the manuscript.

Dedication

To the memory of my beloved mother, Yeshework Zelalem, whose profound influence permeates every facet of this thesis and my life's pursuits. Your unwavering commitment to education continues to inspire and guide me. Thank you for nurturing a passion for learning within me.

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Foremost, I extend my heartfelt appreciation to my supervisor, Dr. Elysee Nouvet. Without your unwavering support, generosity, and capacity to challenge me, this endeavor would not have been conceivable. Your encouragement to explore diverse paths and chart my own course has been invaluable. I am deeply grateful for your insightful feedback and thought-provoking questions, which have propelled me to craft a thesis beyond what I deemed possible.

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List of Abbreviations

APA: American Psychological Association

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,

ICD-11: International Statistical Classification of Diseases; Version 11

HICs: High Income Countries

GMH: Global Mental Health

MGMH: Movement for Global Mental health

LMICs: Low- and middle-income countries

mhGAP: Mental Health Gap Action Programme

MNS: Mental, Neurological, and substance use disorders.

WHO: The World Health Organization

Chapter 1

1. Introduction

> It was a rainy Monday afternoon. In a crowded and busy psychiatric in-patient ward in Bahirdar city, seated on a blue plastic chair against the wall was a slender 35-year-old woman. Her fingers were intertwined in her lap, and her firm gaze remained fixed upon them as she shared the events that had led to her recent suicide attempt, which had brought her to the hospital the previous night. "I don't want to end my life," she disclosed to the two attentive professionals in the room, "but I can't bear to be trapped in this family situation any longer." Y[1]enenesh revealed that she suffered daily abuse at the hands of her husband, feeling like a captive within her own home. The isolation and despair had become unbearable, pushing her to contemplate death as a preferable alternative to her current existence. After she finished telling her story, the psychiatrist dismissed her from the room and promptly determined the diagnosis: depression.

Yenenesh[1] is one of the 350 million people worldwide who experience depression during their lifetime (WHO, 2017; Herrmann et al., 2022). Depression has emerged as a global crisis, with projections indicating that it could become the leading global disease burden by 2030, particularly impacting low- and middle-income countries (LMICs) grappling with complex challenges such as conflict, poverty, and ongoing violence (Herrmann eta l., 2022; Thornicroft et al., 2017; Charlson et al., 2019). Its impact on disability, quality of life, and the economy has prompted calls for scaling up detection and treatment as a public health and development priority in LMICs (Chisholm et al., 2016; Charlson et al., 2019). Global Mental Health (GMH) initiatives have collaborated with the World Health Organization (WHO) to develop tailored series of international intervention programs and healthcare packages for LMICs, such as the Mental Health Gap Action Programme (mhGAP) (WHO, 2008, 2010a, 2016) in response to this crisis. These initiatives aim to enhance the delivery of care and treatment for depressive disorders and other mental, neurological, and substance use disorders (MNS) (Collins et al., 2011).

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[1] Names of all participants have been changed to pseudonyms to protect confidentiality throughout.

Several key factors have shaped the emergence of GMH, most notably the availability of data on the prevalence and burden of mental disorders worldwide, juxtaposed with the shortage of mental health professionals and resources across countries (Saxena & Belkin, 2017). These metrics have played a pivotal role in shedding light on the concept of a "treatment gap," a central issue that GMH aims to tackle (Mills, 2018). It also reveals the glaring lack of accessible mental health care, often referred to as a "hidden emergency" (Funk & Van Ommeren, 2010). The failure to address this crisis is framed within GMH and MGMH as a "failure of humanity" (Kleinman, 2009), and has triggered a moral call to action founded on quantified data highlighting the magnitude of the problem. Depression, as a leading contributor to the global burden of disease, is a critical focal point within global mental health policy (Whiteford et al., 2013).

Consequently, the WHO recommends integrating mental health services into primary health care to close the “treatment gap” and ensure that people in LMICs receive the mental health care they need. Ethiopia, among other LMICs, has adopted the WHO’s Integrating Mental Health into Primary Care (mhGAP) Intervention Guide (WHO, 2008) following WHO recommendations (Keynejad et al., 2018). Depression campaigns have been launched in many developing countries, including Ethiopia. A new language of ‘depression’ has started to circulate through global mental health policy and promotion initiatives aimed at reducing the risk of illness, managing its effects, and governing population distress and well-being in Ethiopia and similar contexts (Rose, 2006).

“Scaling up” access to mental health care has emerged as a core aim of GMH and is framed as a means to close the treatment gap, increase coverage and extend the reach of services (Patel et al., 2018). However, critical reflections on the validity, impact, and sustainability of this scaling up and the treatment expansion it encourages to address depression in LMICs remain sparse. GMH has adopted and reproduced a view of mental health centred on individual pathology (Summerfield, 2012) since its inception. It defines mental disorders as universal phenomena, predicated on Western psychiatric models and nosology, with diagnoses matching distinct biomedical entities with clear biological aetiologies (Bracken et al., 2016; Summerfield, 2012, 2013). This emphasis remains despite scholarly criticisms of its validity (Summerfield, 2006, 2008; Ingleby, 2014: Mills, 2014; Mills & White, 2017; Ecks, 2021).

GMH's conceptualization of mental health and illness shapes how solutions are identified and developed for "scaling up." Viewing mental illness as a universal and technical problem notably renders it amenable to biological and technological interventions and solvable by a change in format and content of service delivery (Applbaum, 2015; Kirmayer& Bemme, 2020). The nature of interventions has often relied on the dominant spatial orientation of GMH's view of mental health and scale, with knowledge and resultant practice being extended through a geographic plane (Mills, 2022). Recently, GMH advocates attempted to answer these criticisms by embracing a "staging model of mental disorders"; however, this reductive model remains focused on symptom-based management and fails to appropriately challenge GMH's reliance on psychiatric diagnosis and classification as "indispensable for clinical practice" (Patel et al., 2018, p. 33).

Health policy making in global health is a complex and multifaceted process that is influenced by a multitude of factors, ranging from scientific evidence and economic considerations to political ideologies and social values (Mills, 2015; Tribe, 2014). In the context of the Global South, where many nations face unique challenges in providing adequate healthcare for their populations, power relations play a crucial role in shaping health policies. These power relations, often driven by historical legacies, economic disparities, and geopolitical dynamics, exert a profound impact on the formulation, implementation, and outcomes of health policies in these regions (Mills, 2015; Summerfield, 2013; Kirmayer & Pederson, 2014).

International organizations and global mental health initiatives, such as the WHO's Mental Health Action Plan (2013-2020), now extended to 2030, significantly impact the development of global mental health policies in LMICs (WHO, 2013, 2022). Despite their considerable influence on shaping mental health care agendas, these organizations may not always take into account the unique contexts and diverse mental health landscapes of individual countries (Bayetti et al., 2023; Bemme et al., 2023; Mills & Fernando, 2014; Mills & White, 2017). Therefore, the widespread propagation of the biomedical paradigm concerning mental illness and depression, circulated through international guidelines, has served as a "condition of possibility" (Foucault, 2010), shaping the emergence of depression as a debilitating global disease, and positioning it as "an illness like no other" (Limenih et al., 2023. p.4). This dissemination may lead to the transfer of subjectivities and potentially result in unintended consequences (Limenih et al., 2023).

Moreover, despite the emphasis of the GMH initiative on advancing mental health interventions in LMICs, a notable concern persists regarding the empirical evidence supporting the biological basis of depression, which stands as one of the most promoted mental health conditions within the GMH framework (see, Summerfield, 2006, 2008, 2012). Critics of GMH have highlighted the lack of attention to socio-cultural contexts and overreliance on standard psychiatric classification systems, neglecting local conceptions of mental illness, experiences of mental health concerns, and approaches to depression and other common mental disorders (Summerfield, 2008; Roberts et al., 2022; Bemme & Kirmayer, 2020; Bemme, 2023; Mills, 2014; White, et al., 2014). This omission is especially striking considering the strong evidence that depression experiences, coping mechanisms, and help-seeking behaviors are influenced by local contexts, idioms of distress, and explanatory models (Ferrari et al., 2013; Kessler & Bromet, 2013; Haroz et al., 2017; Kirmayer, 2001, Kirmayer et al., 2017; Osborn, Kleinman, & Weisz, 2020; Tekola et al.2021).Understanding these local meanings and modes of interpretation can guide effective interventions (Cork et al., 2019 ; Haroz et al., 2017).

1.1. Ethiopian Context

In Ethiopia, health is traditionally defined as a state of equilibrium among the physiological, spiritual, cosmological, ecological, and social forces associated with a person (Alem, et al, 1999; Asher et al., 2021). There is also a set of diverse health beliefs that are often flexible and changing according to the context. However, there is a lack of documented evidence regarding beliefs and perceptions related to depression in the country, with only a handful of studies available (e.g., see Monteiro & Balogun, 2014; Tekola et al., 2021). Little is known about how Ethiopians conceptualize depression, the expressions they use to describe it, the beliefs they hold, or the local idioms and expressions they employ to articulate their feelings and experiences related to depression. It also remains unclear whether expressions of “depression-like” symptoms or conditions of distress are considered an illness amongst the general population. This gap at the clinical level can lead to issues such as under-treatment, overtreatment, or mistreatment for individuals seeking help. Moreover, there is minimal research into how Ethiopians suffering from 'depression' express their views in clinical settings and how depression may be locally conceptualized to develop diagnostic tools.

In recent years, there has been a concerted effort to elevate depression as a crucial medical concern within Ethiopian mental health policies and primary healthcare systems (Ministry of health, 2012; 2015, 2021; Fekadu et al., 2017). This emphasis particularly highlighted medication as the preferred treatment, a focus strengthened by the implementation of the mhGAP at the national level and GMH initiatives. Efforts to improve detection and treatment rates, including routine screening at primary care levels, clinician trainings, and public awareness campaigns, have been thoroughly employed (Fekadu et al., 2017, 2020). While depression is framed as a severe public health issue, there have been limited exploration of the multifaceted social, cultural, political, and economic factors interwoven with depression and societal suffering. In addition, various studies often highlighted the "limited knowledge of mental disorder" among Ethiopian participants and their inadequate "mental health literacy." This concern has led to recommendations for educating mental health workers and the wider community about mental health issues, even as local meanings of depressive symptoms remain uninvestigated (Deribew & Tamirat, 2005; Shibrie & Tefera, 2012; Mekonon et al., 2022).

Efforts in mental health literacy often equate 'knowledge' with the acceptance of medication (Deribew & Tamirat, 2005; Mekonon et al., 2022). Consistent with this view, national health officials and researchers in Ethiopia have perceived the resistance or disinterest in seeking medical care for depression or other mental health conditions as a "communication problem'' or lack of awareness about their mental conditions (see, Deribew & Tamirat, 2005; Shibrie & Tefera, 2012 Mekonon et al., 2022).Too often, the cultural frameworks or explanatory health beliefs of participants are likely considered obstacles and considered as additional layers of meaning to the understanding of depression (Summerfield, 2012; Kirmayer, 2012; Kirmayer & Jarvis, 2019) rather than central organizing concepts. The tensions I have noted, encompassing societal reluctance to seek medical care for depression, the medicalization of depression, and the urgent call by GMH and the WHO to address the 'epidemic' of depression in LMICs), including Ethiopia, has prompted the present critical inquiry. This dissertation was developed to examine the biopolitical rationalities (Foucault, 2008) framing depression as a globally incapacitating 'disease' and a significant public health concern in Ethiopia.

While focused on GMH intervention, policy, and practice related to depression in one country, the approach and findings generated are expected to be pertinent to many more LMIC settings. GMH programs have significantly shaped global mental health policies, legislation, and clinical practice worldwide, but the effectiveness of these standardized international programs in addressing mental health experiences and needs in culturally diverse settings and populations remains uncertain. Shuttling between the global and the very local, this study explore how depression is perceived at the local (Ethiopian) level towards advancing understanding of how localized interpretations and approaches to managing depression can align or diverge from dominant global conception of depression.

This research was driven by two primary objectives: First, to analyze the local conceptualization of depression and how it aligned or diverged from the globalized definition as defined by DSM-5 (APA, 2013) and ICD-11 (WHO, 2022). Second, through (re) reading global mental health as a biopolitical discursive practice (Foucault, 2008), this study examined how a specific body of knowledge was constructed and mobilized in the re-making of space for psychiatric 'subject peoples' in Ethiopia. The study incorporates biopolitical discursive analysis (Foucault, 2008, 2010) and critical ethnographic research methods, including "studying up" (Nadar, 1974, 2008, 2011) depression in the global mental health space (more details below in chapter 3). Nader (2008) emphasizes the importance of researchers 'studying up', 'down', and 'sideways' simultaneously,' suggesting that such an approach can offer valuable insights into the patterns of production, distribution, value, and power dynamics. In the GMH context, where global initiatives exercise substantial power in policymaking and planning for mental health systems in LMICs, the "studying up" approach is paramount. It permits this study to investigate policy discourses and practices that shape the global mental health discourse about depression and substantiated through primary study exploration (detailed further in the method section).

The starting point for this study was the recognition that, in many cases, the process of implementing the globalized concept of depression (e.g., biomedical) into LMICs can problematically negate local beliefs and understandings about mental health and illness, as well as undermine local coping strategies and non-biomedical responses to mental health difficulties.

1.2. Guiding Research Questions and Study Purpose

This study is organized around two overarching research questions : (1) how is the construction and circulation of global psychiatric knowledge shapes/implicated in the understanding of mental illness, particularly for the meaning and management of depression in Ethiopia?; and, (2) how does the global conception of depression fit with the local, specifically with people's beliefs, understandings and practices associated with the expression, causation, and response to depression in Bahirdar City, Northern Ethiopia?

In line with these overarching guiding questions, more specific questions were then explored through analysis of original ethnographic data, and policy documents. These included:

- How does the global conception of depression fit with people's beliefs, understandings and practices associated with the expression, causation, and response to depression in Ethiopia?
- How do mental health professionals and patients conceive of depression in Bahirdar City, Northern Ethiopia?
  - (a) How do patients who are diagnosed with depression narrate their illness: its definition, expression, causation, and response?
  - (b) How do mental health professionals conceive of depression, its definition, expression, causation, and treatment?
  - (c) What challenges were arising from the extensive use of international diagnostic guidelines like DSM-5 within the Ethiopian context and identify how the social and cultural milieu influences the understanding, help-seeking, and management of depression.
- How do the WHO and global mental health conceptualizations of mental illness, and depression in particular, shape Ethiopian National Mental Health policy?
- How do international guidelines, such as the WHO's mhGAP-Intervention Guide 2.0, shape and influence the discourse surrounding depression and the provision of mental health services in LMICs?

These questions are very important as they delve into the multi-level exploration of depression, including the influence of global psychiatric knowledge on local understandings of depression and mental health interventions. By integrating different data sources such as global policy document and discourse analysis with qualitative ethnographic data, this research captures both macro-level frameworks and guidelines shaping depression in the GMH discourse and the micro-level complexities of lived experiences and cultural practices related to depression. The examination of policy implications, including the influence of GMH conceptualizations on Ethiopian National Mental Health policy and the impact of international guidelines such as the WHO's mhGAP-Intervention Guide 2.0 (WHO, 2016), underscores the broader ramifications of global mental health initiatives in LMICs.

My goal in conducting this critical research was not to advocate 'for' or 'against' the goals of GMH. Instead, I have aimed to inquire into what a specific framework or ways of thinking about depression may hinder us from perceiving and what alternative approaches to intervention it might foreclose. The biopolitical discourse analysis framework used to examine the construction of depression in GMH and its interventions in the present research serves to identify how these discourses may constrain our understanding of depression and foreclose alternative approaches to intervention. Only through such exploration can we illuminate the ways in which certain narratives or conceptualizations of depression may serve to maintain existing power structures or reinforce particular norms, potentially overlooking alternative perspectives or approaches that could better address the complexities of depression and its treatment. Biopolitical discourses are: "ways of constituting knowledge, together with the social practices, forms of subjectivity and power relations which inhere in such knowledge and relations between them" (Foucault, 2003. p.146-147). Biopolitical discourse analysis focuses on the ways in which power operates through discourses to govern populations and shape subjectivities, particularly concerning health and well-being (Foucault, 2003, 2008).

Through (re) reading global mental health as a biopolitical discursive practice, this study examines how a specific body of knowledge is constructed and mobilized in the re-making of space for psychiatric ‘subject peoples’ in Ethiopia. Central to this project is exploration of localized meanings and approaches to the management of depression, to understand whether or not and how these align with or diverge from global dominant discourses on depression as defined by DSM-5(APA, 2013)

and ICD-11(WHO, 2022). This involved two key periods of research. I initiated my research by exploring the various biopolitical foundations employed by the WHO and GMH initiatives in framing depression as a severe public health concern affecting both individuals and populations. With analysis of these initiatives' key documents presented in chapters 4 and 5 elucidated the knowledge base of GMH and WHO initiatives to create space for alternative perspectives in addressing depression. I then conducted and analyzed original ethnographic research that included eliciting people's beliefs; understandings and practices associated with the expression, causation, and response to 'depression' in Bahirdar City. While layered, this project's objectives can be summarized as follows:

1. To examine the construction and circulation of global psychiatric knowledge through the analytics of biopolitics, including how such knowledge may play a role in policy, legislation, or individual experiences of depression in Ethiopia.
2. To explore the different biopolitical rationalities about the construction and circulation of depression as a severe public health concern to low and middle-income countries.
3. To explore the conception of depression among patients in Ethiopia.
4. To explore the conceptions of depression at the global level, and examine it how it fits with the local, specifically, with people's beliefs, cultural understandings, and practices associated with the expression, causation, and response to depression.
5. To explore the conception and management of depression among mental health care providers in Ethiopia, including an examination of potential limitations or challenges arising from the extensive use of international diagnostic guidelines like DSM-5 within the Ethiopian context, and identify how the social and cultural milieu influences the understanding, help-seeking, and management of depression.

1.3. Significance and Contribution to the Discipline

This study was designed to articulate and apply knowledge, theory, and practice about global mental health policies and practices regarding depression, a meta-issue relevant to developing and enacting public health policies and practices in all areas of complex health and social policy in Ethiopia and beyond. This inquiry advances theory and practice in the field of global mental health and treatment, specifically with the claim that mental health care should consider and recognize its context - geopolitical, socio-cultural, and the multifaceted range of factors that shaped health behavior - to develop effective treatment approaches (Summerfield, 2012; Ingebly, 2014).

At stake in the debates over Global Mental Health are critical questions about the ways in which socio-economic and cultural realities shape illness experiences and the degree to which proposed strategies for expanding mental health services globally address not only the diversity of lived experiences of illness but also the structural barriers to well-being. The narratives analyzed in chapters 6,7,8 provide rich and detailed insights into the complex ways that health care providers and people experienced depression in Ethiopia, and the ways in which patients oriented themselves to available modalities of healing and strove to ameliorate distress.

Most importantly, this research responds to a need for LMICs mental health research attentive to the values of LMICs and local conceptualizations of mental health in these settings (Haroz etal., 2017; Kirmayer et al., 2017). In the context of an increasingly diverse populace around the world and in Ethiopia, this project provided critical insights on, and a template for, the enactment of processes and practices that could ensure that the values of LMICs and local conceptualizations of mental health/depression helped shape the policies that affected them. Thus, this ethnographic inquiry advances mental health theory, research, and practice, constituting a unique and relevant contribution locally, nationally, and internationally. The study makes significant contributions to the field of global mental health and Ethiopian mental healthcare:

First, through its examination of how mental health professionals and patients conceptualize depression in Bahirdar City, the study sheds light on diagnostic and treatment challenges within the Ethiopian context, informing the development of tailored interventions aligned with local beliefs and practices.

Second, by examining how global conceptions of depression intersect with local (Ethiopian), conception(s), the study challenges dominant narratives within global mental health discourse, advocating for a more contextually sensitive approach to mental health interventions. In other words, this study uncovers the complexities and nuances that are often overlooked in mainstream GMH discourse and challenges the one-size-fits-all approach to mental health interventions and highlights the importance of incorporating local perspectives and practices to enhance wellbeing.

Third, employing a biopolitical discourse analysis framework, the study unveils the power dynamics inherent in the construction and circulation of global psychiatric knowledge. It highlights how certain discourses govern populations and shape subjectivities, particularly concerning mental health, thus contributing to a deeper understanding of the socio-political forces at play in mental health policymaking and practice. Relatedly, the study critically examines the implementation of GMH interventions, particularly regarding depression, in LMICs like Ethiopia. By questioning the validity, impact, and sustainability of scaling up mental health care, it provides valuable insights into the complexities and challenges of applying standardized international programs in diverse cultural contexts.

Fourth, the study integrates macro-level frameworks and guidelines with micro-level ethnographic data, providing a comprehensive analysis of depression from both policy and lived experience perspectives. This approach facilitates a nuanced understanding of the complexities surrounding depression and mental health care delivery in LMICs. In other words, by conducting a multi-level exploration of depression, from the global to the local level, the study prompts a re-evaluation of global mental health strategies, emphasizing the importance of context—geopolitical, socio-cultural, and multifaceted factors—in shaping mental health experiences in LMICs.

Finally, rather than advocating for or against specific GMH goals, the study aims to uncover alternative approaches to understanding and addressing depression. By illuminating how certain narratives or conceptualizations may limit understanding and intervention possibilities, it opens up space for considering diverse perspectives and approaches to mental health care. Overall, this research not only contributes to advancing knowledge in global mental health but also advocates for more inclusive, contextually grounded, and critically engaged approaches to addressing depression and other mental health concerns in LMICs like Ethiopia.

1.4. Roadmap to this Dissertation

The doctoral dissertation consists of ten chapters which encompass conceptual, theoretical, methodological, practical, and reflexive thinking. Although each manuscript is intended to stand alone for publication, they all build upon each other, as they emerged in response to the issues and questions that surfaced in the previous manuscripts. The content of each of these chapters are described below.

In the first chapter, I situate this critical scholarship within international calls related to both the need for expanding the global mental health, policy, and practice to the social realm. Further, I introduce the thesis as a whole, outlining the rationale, the purpose of this critical scholarship, and how each piece adds to the broader aim of the thesis.

Chapter two presents the review of related literature. This chapter consists of four parts. The first part explores and critically analyzes the etiology of depression and discusses the problem of demarcating depression (i.e., the line between depression-as-disorder and non-pathological depressive symptoms) concisely. It also briefly presents the influence of the "practical ontology of depression" in GMH to establish the evidence and propose a solution beyond the practical ontology. The second part of chapter two exclusively attends to the emergence of Global Mental Health and discusses the coming into being of depression in GMH as the "gap" in LMICs and the problem of framing depression as "an illness like any other" through unpacking the global burden of mental illness, depression, and GMH. The third section provides a discussion of the connections between culture, mental health, and/or depression and introduces concepts such as the "looping effect" and "category fallacy." More specifically, it explicates the implication of these concepts in relation to the current discourse of depression in GMH. The final section provides an understanding of the Ethiopian mental health care context. Central to this chapter is situating depression in the current global mental health discourse and available literature.

Chapter three lays out the methodology for the project, including a discussion of the particular theoretical and methodological framework, research design, and tools used to carry out the project, general characteristics of the sample, and ethical complications. Aiming to clarify the epistemological and ontological underpinnings that shape this work, I close this chapter with brief research positionality and reflexive statements.

Chapter four presents the detailed biopolitical analysis of depression and its implications. This exploration serves as a tool to expand the discussion of how depression is taken up in GMH and what evidence has been presented to scale up the treatment services writ large. Importantly, this chapter argues for the need to incorporate diverse epistemological and methodological approaches to address depression in GMH. Consequently, chapters two, three, and four outline key epistemological and theoretical foundations for this dissertation.

Chapter five introduces the first of four integrated manuscripts. It addresses the first research question through a critical biopolitical examination of global-level documents regarding depression. Specifically, using Foucauldian critical discourse and document analysis methods, this chapter explores how international intervention guides operate as part of knowledge-power processes that materialize in certain forms rather than others. Furthermore, this manuscript critically examines the construction of global mental health policy and practice in LMICs, heavily influenced by discourses on mental health treatment and care gaps. The analysis findings identify several resistive discourses and suggest reconceptualizing the treatment gap for common mental disorders.

Chapters six, seven, and eight emerged from primary ethnographic data examining global mental health, biopolitics, and depression in Ethiopia. These chapters explore the ethnographic data, including observations and interviews, to develop socially oriented themes around depression and shed light on local understandings of depression in the context of the global biopolitical framing of the disorder. Specifically, chapter six presents key findings of the dissertation regarding the conceptions of depression among diagnosed individuals and mental health care providers. The chapter underscores that depression is often linked to challenging life circumstances, with Ethiopian social dynamics shaping its interpretation and meaning, emphasizing the integral connection between mental health and societal factors. Moreover, while there is substantial overlap with DSM-5 diagnostic criteria among patients' symptom presentations of their illness, some patient-reported symptoms did not align with the DSM-5 criteria, showing the limitations in global diagnostic paradigms for Ethiopia.

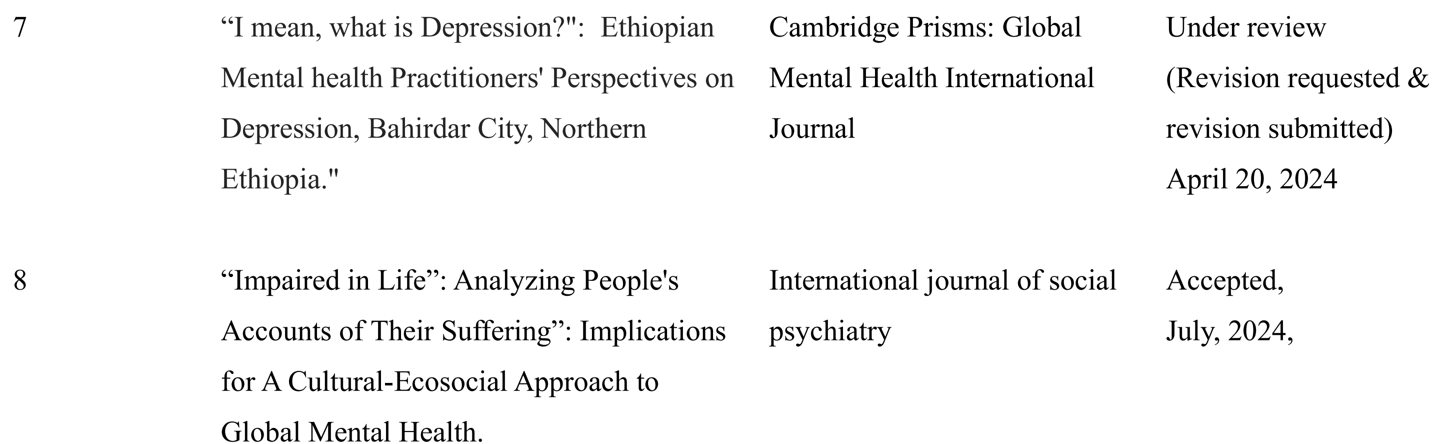
Chapter seven continues the development of themes from the ethnographic data, focusing on exploring the conceptions of healthcare providers about depression, including an examination of potential limitations or challenges arising from the extensive use of international diagnostic guidelines like the DSM-5 within the Ethiopian context.

Chapter 8 presents the illness narrative accounts of patients about depression and its implication to cultural-eco-social approach in GMH. Drawing from cross-cultural and critical psychiatry perspectives, this chapter situate depression within its cultural-ecosocial framework. The findings of this chapter underscore that depression is often described as a state of being "impaired in life," reflecting the complex interplay of individual struggles and societal pressures.

Chapter nine provides a synthesis of the key findings and insights gained throughout the process of developing this dissertation. Finally, Chapter ten, concludes the dissertation, including the implications of this critical scholarship for global mental health research, policy, and practice. Directions for further research and steps are proposed. Among the chapters within this thesis, chapters 5, 6, 7, and 8 stand as independent papers for publication. Some of these papers are already published, in review, or submitted for publication in a peer-reviewed journal following the completion of my doctoral degree. As such, it is worth noticing that there is some repetition across the integrated chapters related to some of the main concepts introduced in this work (e.g., critical epistemological assumptions and utilization of methods). For a full description of manuscript topics and their current publication status, please see **table 1**.

Table 1: Manuscript Publication Status

Chapter Number(s)	Manuscript Title	Journal	Status
5	Depression and Global Mental Health in the Global South: A Critical Analysis of Policy and Discourse	The International Journal of Social Determinants of Health and Health Service	Published, December 2023
6	Understanding Conceptions of Depression Among Patients and Mental Health Care Providers in Bahirdar City, Northern Ethiopia: A Critical Ethnography Study	Culture, Medicine, and Psychiatry An International Journal of Cross-Cultural Health Research	Under Review, Submitted on February 29, 2024



7	"I mean, what is Depression?": Ethiopian Mental health Practitioners' Perspectives on Depression, Bahirdar City, Northern Ethiopia."	Cambridge Prisms: Global Mental Health International Journal	Under review (Revision requested & revision submitted) April 20, 2024
8	"Impaired in Life": Analyzing People's Accounts of Their Suffering": Implications for A Cultural-Ecosocial Approach to Global Mental Health.	International journal of social psychiatry	Accepted, July, 2024,

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Chapter 2

2 Review of the Literature

This chapter presents the review of related literature and consists of four sections. The first part of the review explores and critically analyzes the etiology of depression and briefly discusses the influence of the "practical ontology of depression" in GMH to establish the evidence and propose a solution beyond the practical ontology. The second part exclusively attends to the emergence of GMH and discusses the coming into being of depression in GMH as the "gap" in LMICs and the problem of framing depression as "an illness like any other". It also unpacks the global burden of mental illness, depression, and GMH to establish sound empirical and conceptual argument(s) about how depression has been taken up in the GMH discourse.

Most importantly, this critical analysis is an exploration of how such ways of thinking and practicing mental health may hinder or prevent alternative frameworks or broader solutions to reduce social suffering. The third section presents exclusively the intersection of culture, mental health, and/or depression and introduces concepts such as the "looping effect" and "category fallacy" discusses their implication in relation to the current discourse of depression in GMH. The last section provides an understanding of the Ethiopian mental health care context.

Central to this chapter is situating depression in the current GMH discourse and grounding it in the available literature. As such, this chapter provides a critical and empirical exploration of the epistemic elements of depression in GMH discourse and how they have been taken as the primary target in the current GMH discourse: (1) the category of 'major' depression as defined by the diagnostic manuals, and (2) the epidemiological view emphasizing risk factors of depression and its contribution to the illness expansion. These elements are crucial to the current understanding and practice of depression in GMH since they have been used to produce a space of reasoning in which global claims about depression are presented, problematized, and disputed.

2.1 Exploring the Etiology of Depression

> Those suffering from mental disorders rarely have "lesions" that can be measured, dissected, and analyzed; nor are there visible aetiological agents like bacteria or viruses. Canguilhem George, 1991.

The term depression appears in our everyday conversations around the world. But depression is a very difficult concept to define. Scholars and laypeople usually use the term depression to refer to a variety of conditions, from a disabling chronic disease to a temporary state of mind. For nearly two and a half millennia, depression has been understood as encompassing a wide range of "dejected states" (Jackson, 1986. p.443), including a distinct clinical pathology, a non-pathological mood state, a symptom of another disease, and a temperament or personality type. Early conceptualization(s) of 'melancholia' were associated with symptoms from the overproduction of "black bile" (Khan, 2017) that corresponded to early views on dualism: the distinction of mind-body connections. The compilation of symptoms associated with depression began to take the form of diagnostic categories in the late 19th century (Kendler & Engstrom, 2017), stemming largely from the concept of "manic depressive insanity" and its evolution to 'depressive states' proposed by Emil Kraepelin (Kraepline,1921; Kendler & Engstrom, 2017). While categorical and diagnostic definitions of depression have evolved over the years, there has been significant stability in the core symptoms that have been used (Frances, 2013; Kendler & Engstrom, 2017).

Depression is a common mental illness with an unknown and debated etiology. Explanations often range from biological, to social, to psychological, or to a combination of these emphases (Trivedi, 2020). A common biological explanation is the chemical imbalance hypothesis, which posits that depression is caused by a deficiency of monoamines, such as serotonin and norepinephrine, in the depressed person's brain (Healy, 2004, Kirsch 2010; Moncrieff, 2009). The pharmaceutical industry has promoted antidepressants on the grounds of this hypothesis (Lacasse & Leo, 2005, Frances, 2013; Greenberg, 2010). However, scholars have argued that the chemical imbalance hypothesis is unable to adequately explain depression and have criticized direct-to-consumer advertising for promoting it as a causal explanation (Angell, 2011; Greenberg, 2010; Kirsch, 2010; Leo & Lacasse, 2008; Lacasse & Leo, 2015). The chemical imbalance hypothesis has been called "the potentially dominant cultural story of depression" (France, Lysaker, & Robinson, 2007, p. 411). The limited

efficacy of commonly prescribed antidepressants has been recognized for at least two decades (e.g., Kirsch & Sapirstein,1998; Turner et al, 2008).

Although there are ongoing research undertakings to establish evidence about the biomarker(s) of depression, decades of research in the neurochemistry, neurobiology, and neurology of major depression disease have been unable to identify any biomarker (Garcia-Gutierrez et al., 2020; Trivedi, 2020). Hence, the etiology of depression (or perhaps, to be more accurate, the etiologies of depressions) remains largely unknown, with many different causes at many different levels purported to explain the condition (Kendler, 2012). In the absence of any biomarker(s) or diagnostic test, depression is usually defined as a syndrome: "a co-occurring set of symptoms, signs, and behaviors which form a distinctive pattern and time course" (Kirmayer et al., 2017. p.166).

Currently, in Canada, the United States, and the UK(Euro-American), the term 'depression' is often used to refer to a clinical syndrome known as a major depressive disorder in the nomenclature of the American Psychiatric Association's DSM-5 (APA, 2013). Depression is characterized as a major depressive episode (MDE) by the presence of five or more symptoms that include the following: the diminished interest or pleasure in activities, or sad or depressed mood, and the rest include changes in appetite, sleep, feeling of worthlessness, diminished ability to think, concentrate, or make decisions, and suicidal thoughts or actions. Symptom presentations, however, may vary dramatically from one individual to another, and/ or it appears to be expressed differently in different contexts. The meaning and conceptualization of what depression is, and its objectivity are essentially established and tested in practices and institutions for the treatment of people suffering from depressive illness. Our current understanding of depression has been largely shaped by the epistemic aspects of depression. In the following section, I examined some epistemic elements of depression briefly to lay down a sufficient context for the analysis of global mental health and depression in the upcoming chapters.

2.2. The 'Practical Ontology' of Depression

The philosopher Ian Hacking (1999) once noted that it may be liberating to "realize that something [i.e., depression] is constructed and is not part of the nature of things, of people or human society" (p.35), but what this means must be worked out in any given instance. In the case of depression, there a perpetual tension exists between what is considered 'real' and what is constructed. Therefore,

it becomes imperative to engage in continuous negotiation and re-evaluation in our notion of reality when describing a particular type of mental health condition – like depression.

Contemporary systems of mental health practice have their own culture and history of legitimization of knowledge about depression. Depression has a long history as an illness category in Western (European) culture, dating to the time of Hippocrates (Khan, 2017; Fernando, 2018). The contemporary category we know as depression has its roots in the 19th century Western European melancholia (Berrios, 1996). By 1860 medical dictionaries already included the term "depression," defined as "reduction in general activity ranging from minor failures in concentration to total paralysis" (p. 299). Medical professionals at the time preferred the term depression because it alluded to the slowing of activity and mental abilities as having a physiological cause. However, how we understand depression has remained largely consistent since the classification of Major Depressive Disorder (MDD) in the DSM III—a classification that was heavily influenced by the American psychiatric school of thought (pre-dominantly the Feighner criteria; Feighner, 1972) in 1980. MDD has since become a "gold standard" in clinical practice and research (Frances, 2013; Kawa & Giordano, 2012; Kendler et al., 2009).

The current constructs of depression closely follow the Feighner criteria introduced in the 1960s to advance research on the pharmacological treatment of mood disorders (Healy, 2004; Kirmayer et al., 2017; Kirsch, 2010; Whitaker, 2010). The introduction of antidepressant medication greatly accelerated this process and established an economic incentive for broadening the criteria and bringing many conditions under the umbrella of depression (Healy, 2004, 2009; Greenberg, 2010). One of the major problems with the DSM-III was that it lumped patients based on surface similarities, ignoring their individual differences and context (Frances, 2013; Kendler et al., 2009).

The DSM -III uses the same criteria to define both the most and least severe symptom depressions. This practice has led to "a diagnostic inflation," with the repackaging of every normal unhappiness into a mental disorder (Frances, 2013.p.154). With this 'diagnostic inflation', evidence shows that this diagnostic practice has expanded throughout the past decades to include common mental disorders like depression that shade into the kinds of worries, fears, and demoralization that are part of everyday challenges, adversities, life transitions, and losses (Horwitz & Wakefield, 2007, 2012).

With this expansion, as Annemarie Mol (2001) said, the ontology of depression has been largely dependent on the space of reasoning for practice. This is to say, the ontology of depression has become fused to the practical: "what is, is not detachable of what is done" (p.130). With this conceptualization of depression (ontology) embedded in practice has emerged what philosopher Roy Bhaskar calls an "epistemic fallacy" (Bhaskar, 1975). An epistemic fallacy occurs when the existence of depression is determined and entirely reduced to epistemic elements (the construction of knowledge about that existence) which determine the totality of what depression is. In short, epistemic fallacy happens when we constantly objectify and shape the existence or essence of what something is by how we know it. Therefore, the etiology of depression has continually been contested in contemporary psychiatric practice which has led depression to be established as a disease proper (Healy, 2004; Greenberg, 2010).

The second major factor that sustains depression as a medical problem is a pharmaceutical take over which has shaped the conceptualization and management of depression in the contemporary mental health practice. Contemporary psychiatry has been co-opted by the pharmaceutical and other allied forces of "industry" (Elliott 2011; Healy, 2009; Greenberg, 2010). The pharmaceutical industry and its allies have been accused of disease-mongering in their active encouragement of the medicalization of ordinary ailments (Angell, 2011a, b). The problem has reached a point where even leading psychiatrists openly recognize and discuss these dangers of diagnostic inflation (See, Frances, 2013; Healy, 2004, 2015; Kassirer 2005; Moncrieff, 2009, 2014).

Thus, recent decades have seen an enormous expansion of the range of mood disturbances and other common problems treated with antidepressants, even as evidence for the efficacy of these medications has been challenged (Kirk et al., 2013; Kirsch, 2014, 2015; Lacasse & Leo, 2015). It should be noted that some clinical trials and meta-analyses demonstrate effective outcomes for and safety for several psychotropic medications in certain conditions like lithium in preventing suicide and bipolar disorder (Kandola et al., 2019). However, concerns go beyond the expanding boundaries of what is being defined as a disease, to normative psychopharmaceutical approaches to treatment. As a result, there has been a strong tendency to over-pathologize mild to moderate forms of depression (Horwitz & Wakefield, 2007, 2012; Greenberg, 2010; Moncrieff, 2014, 2018).

In the US, for example, there has been a concerted effort to promote the idea that psychiatric disorders are like other medical conditions, that they can be defined in terms of neurobiological processes, and that the role of the psychiatrist should be centered on applying expertise in neuroscience and psychopharmacology (Kirmayer & Crafa 2014). In this shift, psychosocial assessment and psychotherapeutic interventions have become less central to psychiatric practice (Paris & Kirmayer, 2016). As a result, explanations concerning the causes of depression are becoming increasingly physiological; neuroendocrinological explanations, for instance, have been growing in popularity (Horwitz, 2007, 2015; Greenberg, 2010; Whitaker, 2010).

The third main factor is the notion of risk in research and the trend in addressing depression at a population-level. In psychiatric epidemiology, the concept of risk is closely related to the public health management of depressive illness aiming at prevention, early detection, and early intervention by the means of population screening and making diagnostic practices and treatment of depression in primary health care more efficient (Hellen, 2011; Horwitz & Wakefield, 2007; Trivedi, 2020). The idea of risk greatly facilitated the transformation of depression into a major public health problem. The number of people with a depressive disorder is today enormously larger than 50 or 60 years ago; one can even speak of “a thousand-fold increase in the prevalence of depression” (Healy, 2004. p. 2).

Epidemiology predominantly emphasizes the risks of the depressive illness itself, with the assumption that any of the symptoms listed in the rating scales or DSM-5 (APA, 2013) or ICD-11(WHO, 2022) checklists indicate an increased risk of depression (Frances, 2013). As a result, depressive symptoms are not primarily perceived to be indications of mental illness in the context of today’s depression management. Instead, they are seen as an increased risk of the person developing depression, originating either from his or her life situation or inborn disposition (Trivedi, 2020). In any case, the acute treatments of depressive symptoms or ‘mild depression’ by drugs or by therapy based on talking are largely targeted at the risk of depressive illness and are thus preventive procedures. However, the preventive nature of depression treatment is ambiguous. Because the risk of including common problems as part of depression is over-diagnosis for which there is already evidence as a result, in part, of campaigns to raise awareness about depression and the effort to promote antidepressant use (Dowrick & Frances, 2013).

While this dominant practice influences establishing and maintaining the legitimacy of the concept of depression as a disease proper, at the same time, it reinforces a bio-determinist perspective. Such an arbitrary process of medicalization, whereby subjective – and normative - experiences are redefined as disease or needing treatment (Conrad, 2007; Horwitz & Wakefield, 2007; Dowrick & Frances, 2013), illustrates the construction of knowledge, institutionalization, and legitimization of psychiatric treatment 'norms' in the West (Foucault, 1972, 1980). The consequence of this constructed knowledge about depression is that subsequent research has relied on standard instruments based on a Western nosology of depression and has limited our ability to arrive at a complete picture of depression globally.

Ongoing and intense debates persist regarding the suitability of the biomedical accounts of depression in GMH, particularly it has been adopted the WHO and global mental health initiatives in addressing mental health issues in non-Western contexts (see, Mills, 2014; Ecks, 2021; Roberts et al., 2022; Summerfield, 2008, 2013; Sax & Lang, 2021). Recent calls have urged GMH towards a social paradigm (Bracken et al., 2016; Bemme et al., 2023) and re-consideration of notion of the "treatment gap" and "scaling up" about depression and other common mental disorders (Limenih et al., 2024; Roberts et al., 2023).

This concise review and critical analysis underscores two key points: Firstly, the evolving perspectives on depression over time have mirrored the ideological and political interests prevailing in the West. Secondly, significant concern persists regarding the application of Western mental health diagnoses and treatments in non-Western contexts. Unfortunately, GMH has not adequately addressed these concerns. Instead, it has been adopting a decontextualized approach that not only favors Western frameworks but also solidifies and centralizes these concepts as a universal standard, overlooking the challenges to its assumptions and intervention strategies write large. Indeed, at a time when substantial challenges have been posed to the underlying assumptions of the field as well as its predominant strategies to address mental illness and depression in LMICs, GMH continues its global expansion without robust engagement with the issues of culture and power (Fernando, 2012; Summerfield, 2013). In what follows, I summarized the emergence of GMH, its main debates, evolution, and the current states of GMH to lay down the historical backdrop for the current disagreements over global mental health in sufficient context. Meanwhile, an analysis of these arguments illuminated the political and ideological stakes at play, opening a space for reflecting contemporary debates over culture and mental health and illness.

2.3. Doubling Down and Scaling Up: The Movement for Global Mental Health

2.3.1 The Emergence of Global Mental Health

For the last two decades, there has been growing support for a global mental health agenda, focusing on evidence-based interventions for mental illnesses globally but in LMICs. Reports such as the World Development Report (World Bank, 1993) and the Global Burden of Disease report (Murray & Lopez, 1996) highlighted the substantial burden of mental disorders not only in wealthy nations but also in LMICs. These reports highlighted the global cost of suffering and the significant percentage of loss attributed to mental health issues worldwide (Kleinman, Das, & Lock, 1997).

In 2001, the WHO reported that an estimated 450 million people worldwide are suffering from some kind of "mental or brain disorder" at any given time (WHO, 2001b, p. 6). Furthermore, the report revealed that "14% of the global burden of disease is attributed to neuropsychiatric disorders due to their chronically disabling nature" (Prince et al., 2007, p. 1). The findings also indicated that mental disorders accounted for four of the top 10 leading causes of disability globally and that mental and neurological conditions represented 30.8% of all years lived with disability (WHO, 2001b, p. 3, p. 26). Particularly, the report highlighted that major depression is the leading cause of disability globally and ranks fourth among the ten leading causes of the global burden of disease (WHO, 2001a, p. x). The report further pointed out that "currently, 121 million people suffer from depression, and the burden of depressive illness is rising" (WHO, 2002, p. 1).

Consequently, the World Health Report (2001) revealed that more than 40% of countries had no mental health policy, and over 30% lacked a mental health program (WHO, 2001a, p. 3). The report emphasized that "there is no psychiatric care for the majority of the population worldwide, particularly LMICs, where over 75-85% of the burden lies" (WHO, 2001a, p. xvi). Two years later, in 2003, the World Health Organization (WHO) reported that over 650 million people worldwide are estimated to meet diagnostic criteria for common mental disorders such as depression and anxiety (2003a, p. 17). Furthermore, WHO have estimated that by 2030, depression will be the second biggest disease burden across the globe (Mathers & Loncar, 2006), second only to HIV/AIDS. Thus, this global mapping of mental illness has marked a move to take mental illness seriously on a global scale.

Based on the evidence presented in the above reports, the executive board of the WHO endorsed mental health as the theme for the Round Table Discussions at the 54th World Health Assembly, providing a platform for health ministers in LMICs to collectively address mental health challenges in their respective countries (see, WHO, 2001b, p. 10; Mills, 2014). The objectives of these discussions were to raise awareness of the 'urgent need' to tackle the mental health burden, prioritize mental health on national and international health and development agendas, and garner political commitment for supporting mental health policies (see, WHO, 2001b, p. 10).

In light of this, the Movement for Global Mental Health (MGMH)—an increasingly influential international network of individuals and organizations—was launched in 2008 (see, www.globalmentalhealth.org).In 2007, the Lancet in collaboration with the WHO, published a special series that urgently declared the existence of a global "treatment gap" of mental health care requiring a concerted response (Patel et al., 2007; Prince et al., 2007). The series concluded with a call to global action 'to scale up evidence-based package of services for mental disorders in all countries, but especially in LMICs (Patel et al., 2007).

Following the World Health 2001 Report, MGMH aims "to close the treatment gap" for people living with mental disorders worldwide but especially in LMICs (Patel et al. 2011, p. 88)—"the gap between the huge numbers who need treatment and the small minority who actually receive it" (WHO 2001, p. 6). To achieve this, advocates of the MGMH call to "scale up" the coverage of services for mental disorders in all countries, but especially in LMICs (Chisholm et al., 2007, p. 1241) and to "close the treatment gap" between those who need treatment and the small number who receive it (Chisholm et al., 2011, p. 1242) and believes that this scale-up is the most important priority for global mental health. The World Health Report (2001) thus acted as a surface of emergence for the 'treatment gap' in mental health service between high-income countries (HICs) and LMICs, and within countries, to emerge. The treatment gap here refers to the difference between the levels of mental health needs and the capacity within local systems to address these needs in LMICs. Therefore, the reported 'treatment gap' reinforces the vast inequity: while worldwide at least two-thirds of all persons with mental illnesses go untreated, in LMICs; this figure is said to exceed 90% (Patel & Thornicroft, 2009; Patel et al.2011; Chisholm et al., 2016).

“Scaling-up” has been defined as the process of increasing the number of people receiving services, increasing the range of services offered, ensuring these services are evidence based, using models of service delivery that have been found to be effective in similar contexts, and sustaining these services through effective policy, implementation, and financing (Eaton et al., 2011). The urgency for “scaling-up” services for mental health difficulties has in part been justified on the basis of the moral obligation to act (Patel et al., 2006; Kleinman 2009). Consequently, for the last two decades, MGMH and the WHO have prepared a series of standardized international intervention guidelines and health packages such as mental health Gap Action Programme(mhGAP) (WHO, 2008, 2012, 2013, 2016) to address depression illness along with other Mental, Neurological, and Substance abuse problems (MNS) (Collins et al., 2011) to close "the treatment gap”. As I write these guidelines been implemented in over 120 LMICs (Keynejad, etal.,2018; Mills & Hilberg, 2019).

Further, in 2015, mental health was included in the United Nations (UN) sustainable development goals (SDGs) with the intention of incentivizing programs that address mental health care within international development plans (United Nations, 2015; Mills, 2015). Moreover, the World Bank and the International Monetary Fund (IMF) have advocated for addressing mental disorders globally as a means of increasing economic productivity (Mnookin, 2016). The Lancet Psychiatry formed a Commission on Global Mental Health in 2016, with the goal of developing research and intervention implementation plans for the MGMH (Patel et al., 2016). On October 10, 2018, World Mental Health Day, the Lancet Commission published a report outlining a framework and proposal for “scaling up” mental health care globally (Patel et al., 2018).

The World Health Report (2001) and the WHO Atlas Project (2001), and particularly the tools of measuring prevalence that they employed such as the Disability Adjusted Life Years (DALYs) (Murray & Lopez, 1996) were key in documenting discrepancies and inequalities in global access to mental health interventions and policy. This metric, however, which measures the impact of health conditions on morbidity and mortality, led to mental health difficulties being highlighted as a considerable cause of burden in the Global Burden of Disease study (Murray & Lopez 1996). Results from the GBD metrics on mental health were used to strengthen the call to address mental health as a worldwide problem in the book entitled “World Mental Health: Problems and Priorities in Low-Income Countries” (Desjarlaiset al. 1995). The development of GMH is thus linked to epidemiological enquiry into disease burden and the assumption that mental health difficulties and

their impact are standardizable across the globe (Bemme & D'Souza 2014; Mills, 2014). This in spite of the fact that mental health-related epidemiological data are absent or only partial for much of the world's population (particularly the 80% who live in LMICs), making it inadequate for planning and policy at a global or local level (Baxter et al. 2013, 2014).

Mental health problems had, based on a new method of global health accounting, been identified as one of the greatest contributors to the "Global Burden of Disease" and depression was on track to becoming the most disabling condition worldwide by 2020 (Whiteford et al., 2013). The enormous scope of suffering and unmet need, the series suggested, had not elicited public indignation or an international response towards what Arthur Kleinman called a "failure of humanity" (Kleinman, 2009). The emergence of GMH, however, also elicited a backlash when a number of psychiatrists, transcultural psychiatrists and social scientists began to question the premises of new field. To begin with, there were criticisms of GMH that responded within the logics of evidence-based medicine. Psychiatrist Derek Summerfield posited that the lack of "cross-cultural validity" and western psychiatry's weak evidence base made it irresponsible to export its knowledge to limited resource countries (Summerfield, 2008, 2012, 2013).

More critique erupted in response to GMH's agenda setting article in Nature (Collins et al., 2011.p. 8), which prompted several opposition pieces (Braken et al., 2016; Fernando, 2011; Mills, 2014; Shukla et al., 2012; Summerfield 2013). Concerns have been expressed that the mhGAP initiatives are largely based on mental health services in high-income countries (HICs) that have been heavily shaped by biomedical psychiatry (White & Sashidharan, 2014a). This is occurring at a time when "psychiatry is under criticism as a basis for mental health service development" (Fernando & Weerackody, 2009, p. 196). As such, calls to scale up services in LMICs are co-occurring with calls to scale down the role of psychiatry in many HICs. Fernando (2011), a British psychiatrist, voices this concern when he asks: 'Has psychiatry been such a success here [in HICs] to entitle us to export it all over the world?" (2011, p. 22). Below, is a brief overview of the main arguments leveled against GMH.

2.3.2 The GMH Debates and Fields Current State: An Overview and Synthesis

From its inception, in the MGMH, several vociferous critics have disputed its conceptual, therapeutic, and political bass and it has become the subject of acrimonious controversies. Critiques accused it of exporting a Western model of disorder and treatment, neglecting cultural variability in understanding, and responding to mental suffering and medicalizing distress. In regarding mental distress as a biomedical pathology, critics argue that MGHM diverts attention from the underlining social, economic, and political determinants of illness in LMICs. In these earlier discussions, GMH was perceived as a Euro- American endeavor, perhaps driven by the pharmaceutical industry seeking to expand its markets to LMICs (Fernando, 2011; Summerfield, 2012, 2013; Mills, 2014; Kirmayer & Pederson, 2014; Fernando, 2014).

Specially, the debate around GMH reached a pinnacle between 2012 and 2014 where the critique extended to GMH's foundational elements. There were significant concerns ranges from practical, epistemological, cultural to the political and economic downsides to the approach GMH advocated. There are continuing controversies and debates about the knowledge base (Summerfield, 2008, 2012; Ingleby; 2014), as well as the appropriate methods for establishing priorities, research themes and approaches, and modes of developing and/or adapting interventions to LMICs (Bemme & D'Souza, 2014; Self, 2013; Das & Rao, 2012; Fernando, 2012; Fernando, 2014; Mills, 2014; Kirmayer, 2006; White, 2013; Summerfield, 2012; Kirmayer & Pedersen, 2014).

The strongest critiques described GMH as a neo-colonial imposition of Western psychiatric knowledge on LMICs (Fernando, 2014; Mills, 2014; Summerfield, 2012, 2013) and cautioned that the biomedical model with its underlying assumption of mental illness as a universal brain disorder would replace religious, spiritual, and communal systems of healing and understanding distress (Bracken, Giller, & Summerfield, 2016). Others suggested that local idioms of distress and cultural systems of healing should be taken into account in the production of evidence, e.g., as outcome measures (Fernando, 2014; Kirmayer & Swartz, 2013; Kirmayer &Pedrson, 2014). The critiques also dispute the MNS framework which combines mental distress with neurological disorders and substance abuse and assumes all are underpinned in a pathological neurobiology (Braken et al., 2016). They raise concerns about the influence of the pharmaceutical industry, given that pharmaceuticals often the first and often the only line of the MGMH interventions implicated in

international Guidelines and health packages (mhGap) prepared and distributed to LMICs (Mills & Hilberg, 2019; Mills & Lacroix, 2019; Limenih et al., 2024; Mills &Lacroix, 2019).

The production of evidence itself was flagged as an uneven playing field due to the high cost and specialized expertise required to make knowledge “count” within the register of evidence-based medicine (Hickling, Gibson & Hutchinson, 2013). Some cautioned that GMH prioritizes the distribution of medication over psychosocial interventions (Jain & Jadhav, 2009; Kirmayer & Swartz, 2013) and that the focus on biomedical care forecloses interventions on the social determinants of mental health, e.g., its structural root causes such as poverty, violence, and migration (Kirmayer & Pedersen, 2014; Mills, & White, 2017; White, Jain, Orr, & Read, 2017). Care delivery, some argued, should instead be undergirded by values such as equity and social participation (Campbell & Burgess, 2012; Das & Rao, 2012) rather than economic rationales vying for a “return on investment” (Chisholm et al., 2016).

Most scholars questioned the validity of standardised diagnostic instruments across diverse national contexts, the reliability of epidemiological estimates of the global prevalence of mental disorders and the applicability of evidence -based programs. They claim that local communities are marginalized by the GMH agenda and they suggest that effective interventions must be shaped to the specificities of local cultures, existing local health care systems and the needs of specific population (see, Summerfield, 2008; 2012, 2013; Kirmayer, 2012, Kirmayer & Crafa, 2014, Kirmayer & Pederson, 2014, Kirmayer & Swartz, 2013; Mills, 2014; Mills & Lacroix, 2019). Within GMH, issues around cultural adaptation, language barriers, and power differentials were also discussed, albeit as operational challenges testing the “feasibility” of interventions (Kohrt & Mendenhall, 2016; Lund, 2020; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014).

Advocates of the movement, notably Dr. Vikram Patel, responded to the waves of critique by arguing that global mental health is, in fact, permeated by a concern for justice and human rights. The advocates of GMH further argue that that critiques are based inappropriate equation of global mental health with bio psychiatry, a lack of knowledge about programs being developed on the ground and a failure to recognize the need for a unified policy approach to underpin global metal health’s credibility as a subfield of global health (Patel, 2014). The focus on treatment, they argue

does not prevent either investigation of socio-economic determinants of mental illness or multidisciplinary case studies to inform locally developed social interventions.

Given the long-standing polarization, some scholars viewed GMH as one of the most compressive and least technocratic global mental health movement (Patel, 2014b, Cohen et al., 2012a, 2012b). which brought exciting development to the promotion of mental health issues to the fore and advances research. However, the controversy still stands. For example, in response to the advocates of GMH scholars, Pate Bracken and colleagues (2016) in the paper entitled "Primum Non Nocere" argue that the Movement only pays lip service to engagements with local communities, it is driven by western experts and that in the face of real problem of poverty, and global inequality, psychiatry offered by global mental health is a technocratic and reductionist answer that does more harm than good (Bracken, Giller, & Sommerfeld, 2016).

The other most critical and balanced assessments of dilemma of mental illness in LMICs in response to GMH came from medical anthropologists who have been conducted detailed local beliefs, polices, and evolving practices in relation to mental distress. For example, reviewing many of the studies, Stefan Ecks argues that local ethnographic works throws doubt on many of the claims for success made by the proponents of the GMH. These studies show that many of the changes in mental health care in Kashimir, in Central India, in South Africa, in Togo and elsewhere are claimed by the movement predate its activities and have occurred in response to local issues and campaigns, rather than global mental health policies or interventions. Based on his own research in India (see, Ecks, 2013, 2016; Ecks & Bassu, 2014), Ecks questions the way the data on mental health gap is constructed, point to the fact that there are many generic brands of psychopharmaceuticals on scale in the countries private medicine clinics.

As such, these critics question the uni-directional forms of knowledge transfer (i.e., from HICs to LMICs) or knowledge translation, and the suitability of knowledge translation strategies in culturally diverse contexts (Kirmayer, & Pederson, 2014; Mills, & Fernando, 2014; Summerfield, 2012; White & Sashidharan, 2014). The argument has been made that promotion of a drug intensive psychiatric service that is dominated by pharmacological interventions medicalizes social suffering and eclipses potential approaches to care (Mills &White, 2017; Summerfield, 2012, 2013; Kirmayer, & Pederson, 2014; White & Sashidharan, 2014).

There are still tensions between a public health approach, grounded mainly in biomedicine and evidence-based practices (which are still largely produced in high-income countries), and a socially and culturally informed approach that emphasizes the social determinants of mental health and the imperatives of listening to local priorities, and developing indigenous solutions (Bayetti et al., 2023; Bemme et al., 2023; Kirmayer & Pedersen, 2014; Pūras, 2017; Roberts et al., 2022). As a result, there is an increasing concern in the literature which noted that in the urgency to address disparities in GMH, ways of framing problems and intervening that are not socially relevant and culturally consonant will be exported to local populations with likely negative effects (Fernando, 2014; Mills, 2014; Kirmayer & Pedersen 2014). For example, Kirmayer and Pedersen (2014), argued that "[currently], global mental health tends to be framed in the conceptual 'language of psychiatry' but there are local ways of understanding mental health and social problems that are important to understand, not only because they govern help-seeking and coping but also because they may provide novel strategies for intervention" (P.770).

Cutting across each of these debates are issues surrounding the cross-cultural relevance and application of the Western nosology and its attendant discourses, technologies, and products. Broadly, these can be divided into two discussions: those seeking to improve access to the standard mental health treatments available in the Global North for those in marginalized or underserved populations, both domestically and internationally, and those investigating the social determinants and "global burden of obstacles" to mental health and well-being (Pūras, 2017) that has maintained the status quo. UN Special Rapporteur Dainius Pūras, (2017) identified obstacles such as the dominance of the biomedical paradigm, power asymmetries in policymaking, and the biased use of evidence in mental health. Pūras, (2017) further argued that addressing the 'burden of these obstacles' is a more effective strategy than the current approach dominating mental health policies and services which focuses on the global burden of disorders neglecting the importance of context, relationships, and other important social and underlying determinants of mental health (Pūras, 2017). He stated:

> [currently] there is unequivocal evidence that the dominance of and the overreliance upon the biomedical paradigm, including the front-line and excessive use of psychotropic medicines, is a failure. Yet, around the world, biomedical interventions dominate mental health investment and

> services. When resources appear to scale up mental health services, particularly in low- and middle-income countries, investments tend to be dominated by medicalized service models. I see this not only as a failure to integrate evidence and the voices of those most affected into policy, but as a failure to respect, protect, and fulfil the right to health.

Building upon this understanding, in the subsequent section, I presented a concise analysis of the global burden of depression in GMH. This served to contextualize and problematize the study within the existing scholarly discourse and literature as it examined the intersection of global mental health, biopolitics, and depression in Ethiopia. The depth of this exploration was further unfolded in the subsequent chapters, with a specific focus on integrated articles in chapters 5*, 6, 7, and 8* which were generated from an ethnographic inquiry.

2.3.3 Unpacking the Global Burden of Depression in GMH

Depression is a major focus of concern in global mental health. It has also been increasingly identified as the leading mental health cause of the global disease burden (Chisholm et al., 2016; Ferrari et al., 2013a; Patel et al., 2016; Rehm & Sheild, 2019). Estimates of the global burden of depression in terms of disability, quality of life, and economic impact have also been used to argue for scaling up the detection and treatment of depression as a public health and development priority in LMICs (Chisholm et al., 2016; Patel, 2017). While it seems that depression is widespread and it affects many people globally, studies have suggested a closer look at the global depression "epidemic" (see, Brhlikova et al., 2011; Baxter et al., 2014).

The global burden of diseases (GBD) projections was based on a limited or dearth of data from LMICs and make many problematic assumptions about the generalizability of findings across those populations (Baxter et al., 2013b; Baxter et al., 2014; Brhlikova et al., 2011; Ecks 2021; Ingbly, 2014) (see more detailed analysis below). The use of limited data to generalize about depression prevalence in LMICs have important implications for the accuracy or the validity of estimates of the 'treatment gap' to address depression in LMICs. In 2000, GBD estimated that neuropsychiatric conditions or disorders contribute 14 percent to the total burden of disease in the world and that major depressive disorder ranks as the fourth major cause of disease globally (Ferrari et al., 2013; Murray & Lopez, 1996). The GBD reports concluded that in both developed and developing

countries, depression was the single most burdensome illness accounting for at least twice the burden imposed by any other disease (Collins., et al., 2011).

In the World Health Report (2001), the World Health Organization (WHO)'s first-ever reports dedicated to mental illness, the following statement became iconic: "By the year 2020, if current trends for demographic and epidemiological transition continue, the burden of depression will increase to 5.7% of the total burden of the disease becoming the second leading cause of DALYs lost" (p.5). In the developing regions, "depression will be then the highest-ranking cause of burden of disease" (p.30). Since the earlier prediction in 2001, depression has now been projected to be the leading contributor of disease burden by 2030 (Ferrari et al., 2013; Murray & Lopez, 1996; WHO, 2017; Herrman, 2022). The World Health Report (2001) thus acted as a surface of emergence for the 'treatment gap' in mental health service between high-income countries (HICs) and LMICs and within countries. The treatment gap here refers to the difference between the levels of mental health needs and the capacity within local systems to address these needs in LMICs (Patel & Thornicroft, 2009). The reported 'treatment gap' has served to underline a vast inequity; while worldwide at least two-thirds of all persons with mental illnesses go untreated, in LMICs this figure is said to exceed 90% (Patel & Thornicroft, 2009).

Then, in 2008, the movement for global mental health emerged with its focus on the 'treatment gap' and aims to "scale up" mental health services and treatment coverage for mental disorders in all countries but a special focus to LMICs (Eaton et al., 2011). These figures, so stark and compelling, seem to speak for themselves and serve to underline the need for global and united action. Nearly, every research article on global mental health begins with figures on this global disease "burden," thus again and again (re)producing this burden as incontrovertible fact. Most calls for more research, for new treatments, and for scale-up services within the GMH literature are grounded in these burden calculations, which are empirically questionable and more worryingly, tend to obscure the need for a comprehensive approach to reducing the impact of depression in LMICs.

Claims concerning the prevalence and burdensomeness of mental distress have their roots in epidemiological data attempting to utilize the measures and metrics of physical illnesses for the calculation of statistics related to mental disorders (Bemme & D'souza, 2014). Starting in 1991, the World Bank and the WHO initiated the GBDs in an attempt to quantify the role of medical

interventions in economic development and to assess progress toward them (Murray & Lopez, 1996). One of the indicators utilized by the GBDs to compare different disease categories is the Disability-adjusted Life Year (DALY) metric, which calculates how many years of life are lost to a disease category due to early death or loss of functional abilities from disability.

The 2010 GBD study included "mental, neurological, and substance use disorders," and a key finding was the rapid increase in non-communicable diseases in low- and middle-income countries (LMICs), with the proportion of the burden attributable to these diseases rising from 36% in 1990 to 49% in 2010 (Murray et al., 2012; Charlson et al., 2014). As alluded to earlier, these statistics assume (and reproduce the assumption) that categories of mental distress, such as depression and anxiety apply universally across different cultures and locales. Similarly, in a study for the World Economic Forum, Bloom et al. (2011) attempted to calculate the economic cost of mental disorders, finding that the global cost of these disorders would reach US $6 trillion by the year 2030 accounting for a large percentage of all lost output and productivity worldwide. Going further, a 2016 study estimated that "without the implementation of treatments worldwide, depression and anxiety disorders would cost the 36 largest companies in the world US$925 billion every year" (Chisholm et al., 2016, p. 419). This suggestion of course assumes that it is possible to increase life expectancies through "clinical interventions alone, rather than non-health sector (developmental) interventions" (Das & Rao, 2012, p. 384). Additionally, the "scaling-up" of the treatment of depression is viewed as a strategy for a global "return on investment" (see, Chisholm, et al., 2016; Thornicroft & Patel, 2014; WHO, 2016 a). The most relatively recent reports released by the WHO (2017) suggest that depression impact 322 million people around the globe.

All these reports suggested that prevalence of common mental disorders appears to be increasing most rapidly in the LMICs and "half the number of people living with depression residing in the Global South" (Friedrich, 2017, p. 1517). There are several problematic assumptions made in these calculations, some of which will be addressed below, but the foundational issue remains whether or not mental distress across the globe can be adequately captured by Western diagnostic constructs (Brhlikova et al., 2011; Haroz et al., 2017; Kirmayer et al, 2017; Jarvis & Kirmayer, 2021). The MGMH makes a case for the urgent implementation of standard mental health interventions based on these dire statistics; yet such measurements rest on the problematic assertion, one that has been called into question throughout the history of cross-cultural psychiatry, that culturally specific and

complex experiences of distress can be reduced to illness definitions which are alien in many contexts (Fernando, 2014; Summerfield, 2008).

Doubts remain about the quality of the GBD data and the validity of the disease categories. Even after decades of epidemiological work, the worldwide data remain disputed (Bromet et al. 2011; Baxter et al., 2013; Baxter et al., 2014; Ferrari et al., 2013a; Farmer et al, 2013). An analytical review of the global burden of disease has concluded that there exists significant heterogeneity across epidemiological estimates for depression and “the[c]urrent global burden of depression estimates were ‘epidemiologically flawed and suffers from many problems in terms of representativeness and quality’ (Brhlikova et al., 2011. p.32). As Brhlikova et al. (2011) note, the World Health Report’s (2001), global estimates were based on narrow samples, which make any kind of generalization difficult (e.g., the EURO region had studies relating to 15 out of 52 countries compared to the AFRO region which had studies relating to 3 out of 54 countries).

In addition, one of the major tools used for the projection of the global burden of disease including mental illness measured by DALY (disability-adjusted life years) estimates for Sub- Saharan African countries, have been calculated using the data from South Africa alone (Farmer et al, 2013. p. 228). The patterns and illness experiences across the African continent regarding such simplifications led to ample suspicions. Further, there has been also a dearth of research conducted on mental health in LMICs (Mills, 2014). Indeed, critics have suggested that prevalence figures, such as those concluding that depression is the leading cause of disability worldwide (Friedrich, 2017), “insult our common sense and everyday experience” (Summerfield, 2012, p. 520). As Summerfield (2017) writes, using instruments that assume a “mental disorder’ is an entity essentially lying outside situation, society, and culture, which is identifiable anywhere using a common (Western) methodology,” “cannot be redeemed by reliability–using a standard reproducible method–since the very ground they stand on is unsound” (Summerfield, 2017, p. 52).

The other reason for a nuanced look at the global burden of mental illness ‘epidemic’ data is that although many of the people affected with depression live in non-Western countries, the research that has informed our understanding of the epidemiology, clinical presentation, and treatment of depression has been done primarily with populations in Western settings (Haroz et al., 2017; Kirmayer et al., 2017). Therefore, our present understanding of depression depends on a Western

nosology that might not be generalizable across diverse cultures around the world (see, Bracken et al., 2016; Haroz et al., 2017; Osborn, Kleinman & Weisz, 2021). The argument is that the use of Western-derived instruments to estimate population prevalence of depression worldwide is likely to commit a "category fallacy" (Kleinman, 1988.p.14) (more detailed discussion of its implication below).

A category fallacy, according to Kleinman (1988), implies the direct reification and application of Western nosological categories to people in other cultures for which they are invalid and incongruent. The implication is that, even in clinical settings, category fallacies can result in a diagnostic error as well (Adeponle et al. 2015). It has been long argued that structured screening instruments are unable to effectively assess people's lives since the instruments often portray ordinary distress as a form of psychopathology (Ecks,2021; Horwitz & Wakefield, 2006; Ingleby, 2014; Summerfield, 2008; Patel, 2014). This means that the data collected with these instruments tell us primarily about the prevalence of sadness, despair, fear, or anger among the populations of LMICs, but this can never be a reliable indicator of the prevalence of mental illness. In other words, psychometric measures for depression may mean that a person is feeling sad but is not clinically depressed or ill (Bracken et al, 2016; Horwitz & Wakefield, 2007; Haroz et al., 2017).

One of the leaders in GMH, Dr Vikram Patel (2014) has acknowledged these flaws and called for the abandoning of global burden statistics because they produce a "credibility gap" for psychiatric research (Patel, 2014.p. 18). Patel noted that it was evident that large numbers of people in any country could be said to be "distressed" in the sense of being sad or fearful of the future, yet they were not psychiatrically "disordered" (Patel, 2014). The epidemiology of the global burden of depression is in doubt which challenges the GMH's promotion of depression as an 'epidemic', most prevalent in LMICs, and challenges the notion of the "treatment gap" itself. Many of the psychometric and other measures used for the projection of depression have never been validated on the populations under study in non-western settings, which creates a serious concern that undermines many of the arguments about the 'epidemic' of depression (Ferrari et al., 2013; Summerfield, 2008, 2012). Horwitz and Wakefield (2006) further pointed out that these methods omit a crucial ingredient of all psychiatric diagnoses: the judgment as to whether the supposed symptoms are understandable or experienced as disorder in the context in which they occur.

While in the GMH depression is described within standardized diagnostic systems (i.e., DSM-5 and ICD-11) and in GMH's international intervention guidelines such as mhGap (WHO,2016) as a clinical syndrome, substantial cross-cultural variation exists in its prevalence and symptomatology globally (Ferrari et al., 2013b; Haroz et al., 2017; Kessler & Bromet, 2013; Osborn, Kleinman & Weisz, 2021; Kirmayer et al., 2017). Many symptoms of DSM-5 depression constructs are often not expressed or positioned as signs of distress or illness in non-Western contexts. Instead, 'depression' is a socio-cultural expression of human suffering, varying with different cultures and regions worldwide (see, Kirmayer, 2001; Marecek, 2006; Tekola et al., 2020; Osborn, Kleinman & Weisz, 2021; Roberts et al, 2022; Mayson et al., 2020; Limenih et al., 2024; Limenih et al., 2024(in press).

Haroz and colleagues (Haroz et al., 2017) reviewed the qualitative literature on cultural variations in depression to devise the extent to which current diagnostic criteria fit the experience of people in diverse contexts. They found significant cultural variation and call for an expanded research program to explore the meaning and importance of these cultural variations to understand mental health (Haroz et al., 2017). Similarly, a recent synthesis of qualitative evidence in Sub-Saharan Africa showed that in most cases, depression was deep-rooted in social adversity, predominantly economic and relationship problems, and the researchers found that context shaped narratives of depression (Maystona et al., 2020). As such, the existence of "depression" is not disputed; however, the concept of 'depression' as a unitary psychiatric disorder with objective identification, measurement, and assumed uniformity across sufferers and cultures has faced criticism (see, Summerfield 2008, 2012; Bracken et al., 2016).

In conclusion, conceptualizing depression as a uniform construct for the global population remains a topic of debate and concern. Yet, within the existing discourse and policies of GMH, depression is primarily depicted as a "mental disorder" – a biomedical construct highlighting it as an individual pathology best addressed at primary health care facilities. The underlying assumption here is that human emotions and behaviors can be understood independently of context, with the identified 'symptoms' considered equally pathological wherever they are encountered (Bracken et al., 2016). This firm belief in the underlying biological universality of depression is misleading, given the various culturally shaped forms of its expression. Numerous studies have consistently shown substantial cross-cultural variation in the prevalence, symptomatology, and clinical presentations of

depression worldwide (Ferrari et al., 2013b; Kessler & Bromet, 2013; Haroz et al., 2017; Maystona et al., 2020).

Over the past fifty years, cross-cultural psychiatry and other mental health professions have increasingly recognized the critical role of sociocultural factors in mental illness. This acknowledgment has led to the development of new conceptual and methodological frameworks, positioning cultural factors as major determinants of the onset, expression, course, and outcome of mental disorders (Kleinman, 1977, 1988; Kirmayer, 2001, 2006; Summerfield, 2008). Despite this clear evidence, there is an underrepresentation of this notion in mainstream psychiatric and GMH literature and policy, which tends to overemphasize cross-cultural similarities and minimize differences, often grounded in biomedical lenses (Bracken et al., 2016).

As a result, from this analysis, several problematic assumptions about depression within the current GMH policy and practice emerge: (***1***) the assumption that depression can be objectively identified and measured uniformly across sufferers and cultures, (***2***) the notion that depression primarily has a biological origin, (***3***) the belief that the world is currently facing an "epidemic" of depression, and (***4***) the idea that the most appropriate treatments for depression typically involve psychopharmaceutical drugs. In light of the current conceptual and epidemiological ambiguity surrounding depression in GMH practice, it also prompts two critical questions: (***1***) Was or is there indeed a "treatment gap" for depression, as conceptualized by experts whose global estimates consider individuals in LMICs suffering from 'depression' due to a lack of diagnosis or psychiatric help-seeking? ***(2)*** are there many individuals in LMICs who have been experiencing 'depression", necessitating increased depression awareness programs for professionals and the public alike? Most significantly, the assumption that LMICs in the Global South lack culturally specific ways of responding to mental distress, along with the implication that quantitative metrics should be taken literally, contributes to a sense of urgency in GMH. This led has led to the development of simplified and resource-poor interventions that are increasingly technical rather than holistic (Bemme & Kirmayer, 2020).

2.4. Culture and Mental Health

Arguments about the role of culture in psychiatry are as old as the discipline itself (Jilek, 1995). Edward Tylor (1871, p. 1), defined culture as "the complex whole which includes knowledge, belief, art, law, morals, customs and any other capabilities and habits acquired by man (and woman) as a member of society." It is what people learn to believe about the natural and supernatural and our place in it, how we should make our living and how we should behave (Singer & Erickson, 2013; Nichter, 2008). Similarly, Erchak, (1992), states that culture includes a group's beliefs, values, norms, myths, and it has at least three aspects: mental (brain and consciousness), material (related to basic needs and modes of survival), and social (relationship and society). Culture also encompasses "deeper, latent processes that are less easily identified, such as worldview, epistemology, theological perspectives and implicit ethics, ideals and morals'' (Monteiro & Balogun, 2014. p.520). Culture, in this sense, is the primary means humans use to understand and cope with changing local, national, and global challenges and opportunities in the world; human nature is cultural as a consequence (Singer & Erickson, 2013; Jarvis & Kirmayer, 2021).

Most relevant to health, culture shapes our ideas about what makes us sick, what makes us well, and what kinds of healers we use and trust in our quest for 'good' health (Kleinman, 1977, 1980, 1988; Jarvis & Kirmayer, 2021). Thus, the conceptualizations of illness and health are rooted in the 'common- sense' knowledge of the society in which they operate because the actions, beliefs and motives that provide the basis for understanding illness has been conceptualized in unique ways depending on the society (Castillo, 1996; Kleinman, 1980). In the context of mental illness, previous studies documented that culture influences how individuals manifest symptoms, communicate their symptoms, cope with psychological challenges, and their willingness to seek treatment (see, Kleinman, 1977, 1980, 1988; Castillo, 1997; Kirmayer, 2006, 2012; Jarvis & Kirmayer, 2021).

The diversity in how mental illnesses is understood can be found across cultures and can be seen across time as well (see, Hacking, 1998; Foucault, 1967, 1977). Because the 'troubled mind' has been perceived in terms of diverse religious, scientific and social beliefs within discrete cultures, the forms of 'madness' from one place and the time in history often look remarkably different from the forms of 'madness' in another (Benedict, 1934; Hacking, 1995, 1998; Foucault, 1965, 1977, Castillo, 1996; Porter, 2006).

Culture can function as a determinant of mental health in its own right (Kirmayer & Jarvis, 2019). In this context, cultures provide modes of self-understanding and frameworks that shape our identities, life goals, and aspirations (Kirmayer & Jarvis, 2019). Consequently, culture contributes to the causes of mental health problems, impacting symptoms, illness experiences, expressions of distress, coping mechanisms, help-seeking behaviors, treatment responses, social stigma, and recovery (Kirmayer & Jarvis, 2019; Jarvis & Kirmayer, 2021). This dissertation centres its core argument emphasizing the pivotal role of cultural knowledge, values, and practices in creating, maintaining, and sometimes rationalizing or concealing health inequities. Addressing these inequities requires systematic attention to culture in health policy, research, training, and transforming care systems.

2.4.1 Category Fallacies and Epistemic Injustice in GMH

Kleinman (1988, p. 14) introduced the concept of a "category fallacy," signifying the direct imposition and use of Western nosological categories on individuals in different cultures where these categories are inappropriate and mismatched. This imposition often results in what is termed as "epistemic injustice" (Fricker, 2003). Cross-cultural studies that adopt established diagnostic constructs are limited in their capacity to identify the adequacy of existing frameworks. However, such studies can reveal problems with categories. For example, Haroz et al. (2017) examined qualitative studies of depression in the global English language literature that indicate that some common symptoms associated with depression are not included in official diagnostic criteria. The result may be that DSM-5/ICD-11 depression is underdiagnosed in non-European populations, perhaps because local concepts of distress are not recognized by trained clinicians. These studies also point to the possibility that other constructs might better capture forms of distress that overlap with depression as defined in official nosology (Kirmayer et al., 2017; Osborn, Kleinman, & Weisz, 2020).

The diagnosis of mental health problems in cross-cultural context poses at least two basic epistemological dilemmas that have been framed in terms of the "category fallacy" (Kleinman, 1980) and looping effects (Hacking,1999). The category fallacy arises from the fact that interpreting symptoms exclusively through categories derived from one culture may preclude discovering local (and potentially more accurate or useful) ways of characterizing distress (Kleinman, 1987). The imposition of such "etic" categories blinds the researcher or clinician to local "emic" cultural reality. In clinical settings, category fallacies can result in diagnostic error (Adeponle et al. 2015). On the

other hand, the concept of looping effects refers to the tendency for social categories to reshape human experience so that it conforms to the category (Hacking, 1999). Jarvis and Kirmayer (2021), reading Hacking, further state that "looping effects can occur at many levels within the body, between the body and interpersonal interactions, and between individuals' cognition and the social world" (p. 7). In this way, cultural categories and constructs become self-vindicating social realities. For example, the clinical use of the category of depression has enabled people to reinterpret suffering in ways that change their experience and expectations for treatment and that influence clinical diagnostic practice in a self-confirming loop (Brinkmann, 2005; Hari, 2018). According to Hacking (1999), looping effects are ubiquitous and apply to concepts of self and social behaviors in addition to categories of medical or mental disorder.

The epistemic problems of category fallacy and looping effects are relevant to the aspirations of global mental health. Psychiatry has participated in a form of cultural hegemony in which Eurocentric symptoms linked to depressed states are assumed to exist in all settings and to signify cases of depression in the people with the symptoms (Kirmayer et al., 2017). Category fallacies can occur with any form of distress and constitute a major challenge to the cross-cultural validation of mental disorders (Kirmayer & Ban, 2013; Kleinman, 1977). To avoid the category fallacy, Kleinman emphasized the importance of ethnographic research that explores local modes of suffering and symptom experience as well as diagnostic practice. Interestingly, Kleinman's later research in China revealed looping effects as his own studies began to influence Chinese psychiatric practice (Kirmayer, 2006; Kleinman, 1986).

The important point to note is that category fallacies and looping effects can arise both within cultures and in inter-cultural contexts in which an illness category imported from one society to another acquires a privileged position such that symptoms in the new setting are only recognized and treated if they fit the extrinsic category (Kirmayer & Jarvis, 2021). As this new framework for distress becomes widely adopted, it can reshape illness experience, leading individuals to focus on sensations and interpret symptoms in ways that conform to the imported model. Through looping effects, then, such categories may come to dominate or erase indigenous concepts, with unknown effects on well-being (Kirmayer, 2012).

In essence, cultural frames play a significant role in shaping and influencing every facet of human existence (Kirmayer & Bhugra, 2009). Specifically concerning mental disorders, these frames mold the experience, expression, and interpretation of individual symptoms. They also dictate how mental health professionals identify, classify, and address distress. Moreover, the cultural frames establish enduring conceptual paradigms and models that shape both public perceptions of mental health and illness and professional practices (Kirmayer & Jarvis, 2019, 2021). The complexity of mental disorders across diverse cultures necessitates an understanding of cultural frames. However, it is important to note that these frames are inherently partial, revealing certain aspects while concealing others, including aspects of professional culture. Despite occasionally restricting our viewpoint, these cultural frames harbor potential meanings that can inspire innovative approaches to dealing with challenges in our constantly evolving world (Kleinman, 1980; Kirmayer & Jarvis, 2021).

2.5. Understanding the Ethiopian Context

2.5.1 Explanatory Models

In Ethiopia, health is traditionally understood as, a "state of equilibrium among the physiological, spiritual, cosmological, ecological and social forces associated with a person" (Vecchiato, 1993; Monteiro & Balogun, 2014; Wondie & Abebaw, 2019). Whilst this holistic framework bears some resemblance to the biopsychosocial model, increasingly favored to explain health and disease states in the West (Engel,1980), the prominence of spiritual explanations gives a distinctive essence to Ethiopian concepts of health. Descriptions of explanatory models for mental illness in Ethiopia have traditionally focused on supernatural explanations (Giel etal., 1968; Kortmann, 1987; Mekonon et al., 2022; Baheretibeb et al., 2021; Asher, 2021).

More recently, accounts of Ethiopian explanatory models have expanded to include a broader more pluralistic set of beliefs encompassing both supernatural and psychosocial causes; along with recognition that these apparently conflicting beliefs often exist within the same community and even the same individual (Baheretibeb et al., 2021; Teferra & Shibre, 2012; Asher et al., 2021). The capacity to hold several beliefs at once, which may be contradictory, has been described as 'cognitive tolerance' (MacLachlan,2006) and is a phenomenon observed in both LMIC and high-income settings (Mulatu, 1999). It has been noted that whilst phenomenological models may be in use by a traditional healer, an aetiological classification (for example, spirit possession) is almost always provided for the patient, as a way to give the illness experience meaning (Patel,1995; Mayston et al., 2020).

2.6. Mental Health Care in Ethiopia

2.6.1 Healthcare System in Ethiopia

Ethiopia's healthcare system comprises a three-tiered delivery system (***see, fig 1),*** including primary health care units (health posts, health centers, and primary hospitals), general hospitals, and specialized hospitals (Ministry of Health, 2015). Tertiary healthcare institutions, including specialized psychiatric facilities and teaching hospitals, play a pivotal role in diagnosing, treating, and researching depression. Level one, at the district level, is a primary health care unit comprising of a hospital (for 60 000–100 000 people), health centres (for 15 000–25 000 people) and their satellite health posts (for 3000–5000 people). Level two is a general hospital for 1– 1.5 million people and level three is a specialized hospital for 3.5–5 million people. In addition, there exists a rapidly expanding private sector (Ministry of Health, 2021). Health centres are staffed by health officers (four years of training) and general nurses (of degree or diploma level). Each health post covers a sub-district (kebele) and is staffed by two health extension workers. Health extension workers are high-school graduates with one year's training in health promotion and illness prevention. They are all women residing in the sub-district where they deliver health education and basic interventions to households.

A recent expansion of primary care facilities has reportedly improved geographical access to health services, resulting in an estimated 92.2% potential health service coverage. However, health care utilization remains low as a result of economic, sociocultural and geographical factors (WHO, 2013). Health care costs are largely out-of pocket and there are no health insurance schemes. A fee waiver is available for the poorest, with certificates given at the discretion of sub-district officials. The WHO categorizes Ethiopia as having a critical shortage of health care workers, with uneven distribution of resources, poor skill mix and high attrition of trained health professionals being particular concerns (WHO, 2013). There is generally low availability of medicines due to an unreliable supply system and long procurement procedures. Availability of essential medicines is 52% in the public sector and 88% in the private sector (WHO, 2013).

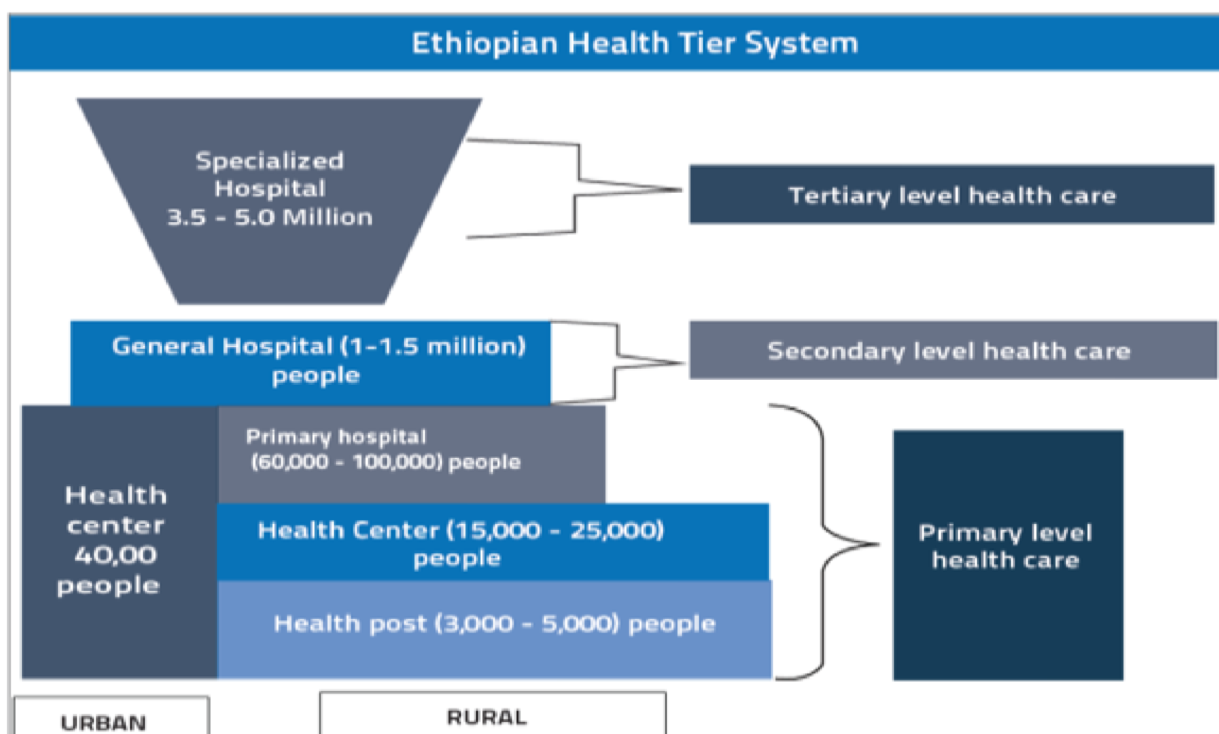

Figure 1: Ethiopian Health Tier System (Adopted from National Mental Health Strategy 2020-2025 (Ministry of Health, 2020).

2.6.2 Biomedical Services for Mental Health

In Ethiopia formal mental health care is very limited and is almost entirely based in Addis Ababa and other major cities (Fekadu *& Thornicroft,* 2014). For a population of 97 million people, the main sources of care are Ammanuel Psychiatric Hospital in Addis Ababa (268 beds), two small inpatient units, four outpatients' clinics and 57 nurse-led psychiatric units in other cities (Ministry *of Health*, 2012). In the last 15 years several Ethiopian universities have begun training programmes in community mental health and psychiatric nursing. However, it is unclear whether these developments have translated into increased provision of mental health care. Currently, mental health care is generally not available at the primary care or community level. The 2012 National Mental Health Strategy of Ethiopia represented an important development in mental healthcare provision. The Ministry of Health has committed to move towards integrating mental health into primary care, guided by the WHO's mhGAP, and is currently piloting this model in several sites across the country (Lund et al., 2012; Ministry of Health, 2012; Fekadu et al., 2015). Of central importance is that prescribing privileges for antipsychotic medication are to be extended to general nurses and health officers. The 2012

Mental Health Strategy promised to allocate specific funding for the implementation of mental health in primary care (Ministry of Health, 2012). As Ethiopia's mental healthcare system evolves and expands, addressing mental illness including depression at both primary and tertiary health care levels becomes crucial within the broader mental health strategy. Notable initiatives, including the Health Sector Development Plan (HSDP-IV), which aimed to have 50% of health facilities offering integrated mental health care, and the pilot implementation of WHO's mhGAP, were launched to expedite this integration (Ministry of Health, 2015; WHO, 2013). The country's new mental health strategy for 2021–2025 mandates the integration of mental healthcare into every primary care facility nationwide (Ministry of Health, 2021). This transformation is especially significant, given Ethiopia's historical neglect of mental health services (Mekonon et al., 2022).

2.6.3 Pathways to Mental Healthcare

Recent systematic reviews have shown that approximately half of individuals who seek biomedical care for mental disorders in Africa have previously chosen traditional and religious healers as their first care provider (Burns, &Tomita,2015; Gureje et al., 2015). An Ethiopian study found that of 1044 patients that attended Ammanuel Psychiatric Hospital over a two-month period, only 41% came without having previously sought help elsewhere. Among the remaining patients, 40% initially sought help from holy water priests or a church, 21.5% consulted doctors other than psychiatrists in private or government hospitals, 4.5% contacted herbalists, and 2% saw general nurses or psychiatric nurses (Bekele et al., 2009). A study in Southwestern Ethiopia found similar results, with over half having attended a religious healer (30.2%) or a herbalist (20.1%) prior to attending a psychiatric inpatient unit (Girma &Tesfaye, 2011). There is little data on time trends in use of traditional forms of care in Ethiopia or other LMICs (Gureje, et al., 2015). Interventions that seek to engage people with schizophrenia in biomedical care need to be cognisant of the other treatment options available, and why they might be chosen as an alternative.

The decision-making processes around choosing a care provider from the diverse range of options are not fully understood (Johnson et al., 2012; Baheretibeb et al., 2021), though studies in Butajira and Northwestern Ethiopia have found that biomedical care is more likely to be recommended for

physical conditions compared to mental health problems (Mulatu,1999; Alem, et al., 1999; Mekonon et al., 2022). Furthermore, it is proposed that many families have a pragmatic attitude towards seeking care for their relative, trying different options until they strike on something which appears to be effective (Teferra & Shibre 2012; Girma &Tesfaye, 2011).

People in LMICs such as Ethiopia may be more inclined to use traditional or religious healing for mental health problems not just because this provides the most obvious link to popular explanatory models (Asher et al., 2021; Mekonon et al., 2022; Limenih et al., 2024(in press)). Greater accessibility and affordability of traditional healers and holy water are also like to be important factors, along with more flexible payment options (often traditional practitioners only receive the full payment on cure) (Gureje, et al., 2015). Attending a traditional or religious healer may have greater cultural and social acceptability; the average rural Ethiopian may be more likely to share a worldview and lifestyle with traditional healers compared to biomedical providers (Mulatu,1999). There may also be less stigma associated with attending a traditional healer compared to receiving a psychiatric diagnosis (Gureje, et al, 2015).

2.6.4 Mental Illness Etiology in Ethiopia

Previous studies on mental illness in Africa and Ethiopia highlight the role of supernatural/spiritual explanatory models in conceptualizing mental illness (Geil, 1968; Monteiro & Balogun, 2014; Tekola et al., 2023; Asher, et al., 2021). These supernatural conceptualizations emphasize the importance of understanding the causes of symptoms which could include spirit possession, being the victim of a bad spell or not being protected spiritually in order to develop the most appropriate treatment approach (e.g., appeasing spirits through ritual, performing exorcism or seeking spiritual protection) (Monteiro& Balogun, 2014). Remedies are then classified by type of supernatural cause, symptom constellation and patient characteristics (Collignon & Gueye, 1995). In addition, Ethiopia has a long history of traditional health beliefs and practices. An extensive body of Ethiopian medical literature, including translated texts of diagnoses and cures (Pankhurst, 1968), reveals that, in general, Ethiopians believe health is derived from a state of equilibrium within the body, as well as balance between the individual and external world (Vecchiato, 1993; Wondie & Abebaw, 2019).

Traditionally, it is believed that mental illness can be caused by the malevolent wishes of evil-minded people, bad spirits, the evil eye (buda) and the hostile feelings, ill will and envy of common people. Although these causes are external, the sufferer is believed to bear some responsibility for the problem, for example by offending spirits or provoking envy (Vecchiato, 1993). Other findings indicate that people believe traditional treatments are best for spirit possession (Alem, et al., 1999) as well as epilepsy and mental retardation (Mulatu, 1999). The backdrop of traditional Ethiopian ideas about illness is a worldview in which spirits, words and intentions are all interconnected and believed to influence the outcome of events (Giel, 1968). Traditional beliefs also distinguish between temporary and permanent 'insanity'. For example, some behaviors, such as walking naked, begging, wandering around aimlessly and talking to oneself, are labeled cases of incurable mental affliction (Mulatu, 1999).

Mulatu (1999) speaks to the multidimensional character of Ethiopians' illness causal beliefs that 'reflect the sociocultural context in which they occur' (p. 547). This context includes the centrality of social relations in maintaining mental health and treating mental illness, the recognition of socioeconomic and biological factors in causing vulnerability to mental illness and the importance of cultural and social values in making sense of and treating mental illness. Several studies have also investigated contemporary attitudes about mental illness. Alem et al. (1999) examined key community informants' beliefs and practices regarding mental illness in a rural Ethiopian town. They found that the prototypical symptoms of mental illness were reported as talkativeness, aggressiveness, strange behavior, wandering, nakedness, self-neglect and destructiveness. The symptoms considered the most serious were those associated with the DSM diagnosis of schizophrenia, as well as mental retardation and epilepsy. Symptoms associated with the DSM depression diagnosis were rated the least severe. Mulatu's (1999) findings identify four causal belief dimensions for mental illness: psychosocial stressors, supernatural retribution, biomedical defects and socio-economic deprivation. Ulman and Minas (1977) found that Ethiopian respondents listed worrying too much, poverty and death of a family member as causes of mental illness. Finally, Patel (1995) cited thinking too much as commonly listed explanations for mental illness in Ethiopia.

Despite the history of these traditional beliefs and treatments, there is currently a gap in mental healthcare in the country due to economic constraints and the inadequacy of these traditional explanations alone to address the current manifestations of mental illness in the country. In order to assist in properly diagnosing mental illness in Ethiopia, it is important to understand Ethiopians' more recent perceptions of the symptoms, causes and preferred treatment for specific mental illness. Standard psychiatric diagnosis is based on the presentation of universal symptoms and patterns of behavior. Instruments developed to aid in making DSM diagnoses typically focus on the broadest and most common symptoms across cultures. To be clear, numerous studies support the high disease burden of mental illness based on assessing these universal symptoms. Keegstra (1986) used the Standardized Assessment of Depressive Disorders (SADD) to assess psychiatric outpatients in Ethiopia. Results indicated that patients exhibited core depressive symptoms, with somatic complaints, specifically burning sensations or pain in the head, being prominent.

In a study of patient diagnoses at a psychiatric clinic in Addis Ababa, Khandelwal and Workneh (1988) explained the role of somatic complaints in Ethiopian patients' expression of mental illness. They suggested that patients often embellish their problems with physiological complaints to get the doctor's attention in busy clinic settings. Other research in Africa underscores people's association of behavioral features with psychotic disorders and cognitive and somatic features with neurotic disorders (Patel, 1995). As Alem et al. (1999) concluded, many traditional beliefs and popular lay beliefs are strikingly aligned with modern medicine. However, research also highlights problems identifying culture-specific psychiatric symptoms using Western developed instruments. Studies using the Self Reporting Questionnaire (SRQ) (a psychiatric case finding instrument developed by the WHO) and similar instruments in Ethiopia have discovered difficulties due to problems in cultural communication. Kortman (1990) found that the SRQ had moderate validity in a group of clinic outpatients, but revealed problems when Ethiopian patients were exposed to the language of Western psychiatry. The SRQ's sensitivity to health-seeking behaviors and its inability to decipher the meaning of such behaviors for Ethiopian patients was problematic.

2.7. References

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Chapter 3

3 Theoretical Framework and Methodology

This chapter discusses the methodology and theoretical framework for the project, including a discussion of the particular methodological framework and tools used to carry out the project, general characteristics of the sample, and ethical considerations. This chapter also provides information regarding my position as a researcher, and the epistemological underpinnings that shape this work as well as a brief research positionality and reflexive statements.

3.1. Theoretical Framework

3.1.1 Biopolitics

The dissertation examined the praxis of global mental health research, intervention, policies, and practices about depression. This study was designed with recognition that in many cases, the process of exporting the globalized conception of depression (e.g., Euro-American) into LMICs happened without consulting the local beliefs and understandings about mental health and conversely, illness and the responses to mental health difficulties. Concerns remain about how knowledge is generated, how concepts are defined, and which individuals and institutions have the power to define concepts in global mental health, what values influence and are reflected in global mental health priorities and praxis. Thus, the conceptual questions that this study raised were related to what the different biopolitical rationalities (Foucault, 1977, 2004, b, 2008), mobilized by the WHO and global mental health initiatives about the construction of depression as a severe public health problem for individuals and populations in LMICs, with a focus on Ethiopia.

In order to understand the biopolitical processes and answer these questions, I have used Michael Foucault's philosophical guidelines and theorizing on biopolitical discourse, power, and knowledge (Foucault, 1975, 1977, 2003, 2008), and a broader perspectives drawn from critical and cross-cultural psychiatry scholarship and perspectives, allowing us to position depression within its eco-social context (Bhugra & Bhui, 2018; Gómez-Carrill et al., 2020; Kleinman, 1980, 1988; Kirmayer et al., 2017; Gómez-Carrillo, & Kirmayer, 2023; Kirmayer, 2019; Gómez-Carrillo et al., 2023a).

Within this approach, the understanding and response to an illness, such as depression, are shaped by local cultural models and interpretive systems, and any illness must be understood in its formations, meanings, and impacts within its social milieu (Kleinman, 1988; Kirmayer, 2019). This approach demands a systematic examination of the social-structural determinants of illness and recognizes illness as a deeply personal experience influenced by socioeconomic, cultural, and political factors (Kirmayer, 2019).

Reflecting this understanding, my theoretical approaches for this dissertation brought together the ways of understanding about health, illness, and mental health as broadly conceptualized in the sociopolitical, economical, historical, and ecological context of a particular country (Farmer, et al., 2013; Biehl & Petryna, 2013; Kirmayer, 2019; kirmayer & Jarvis, 201*9, 2021*). Primarily, however, this study was informed by Michel Foucault's concept of biopolitics (Foucault, 2003, 2008, 2011) (see expanded discussion of the concept below). Foucault in his later works focused on knowledge, biopower, and discipline and their inter-relations, which operate through the mechanisms of discourse or discursive practices (Foucault, 2008). A discursive practice according to Foucault is "the process through which [dominant] reality comes into being"(Foucault, 2003). The management of life, which Foucault refers to as 'biopolitics' is performed through a variety of means and techniques, practices and procedures that are aimed at organizing, regulating, and governing the phenomena peculiar to life in the context of population (Foucault, 2003, 2008). Foucault further argued that the knowledge shaped by discourses, empowered by institutions, and exercised through techniques and practices thus has the power to make itself true (Foucault, 2003, 2008, 2011).

Foucault claimed that power is irrevocably connected to knowledge, which in turn has a regulatory function, for example, through categorizing what is normal and abnormal; what is `mad' and what is `sane'. (Foucault, 1987). For Foucault, (1976. p. 243), "an apparatus is a texture of entwined discursive and extra-discursive practices – however heterogeneous – that articulates itself in the forms of what we could define as an acted-out knowledge". According to Foucault, such apparatus typically interlaces the said and the unsaid in a 'making' and re-making of the world. In other words, an apparatus is a mechanism, which makes some things more visible. Therefore, the apparatus is a system of power relations internal to the' making' and its typical function is to respond to an urgent need. In this view, discursive practices produce identities, subject positions, and `institutional sites/ norms from which a person can speak or be addressed, as subjectivity is not conceptualized as

coming from within, but rather as constructed within the language and cultural practices (Foucault, 2003).

Foucault argued that the knowledge shaped by discourses, empowered by institutions, and exercised through techniques and practices thus has the power to make itself true (Foucault, 2003, 2008, 2011). Similarly, Bhabha's (1983, p. 26), reading of Foucault asserts that the power relations at work within 'an apparatus' "are always a strategic response to an urgent need at a given historical moment." This notion of biopolitics then opens (re) reading of WHO and global mental health initiatives, as an apparatus that operates as a 'strategic response' to the contemporary 'urgent need', the global 'emergency' and 'epidemic' of mental illness and depression. In line with this perspective, while global mental health recognizes the political significance of mental health by considering it a priority on the international agenda, it paradoxically overlooks the political aspects by universally applying psychiatric technologies, predominantly medication-based approaches. This is because to claim the universality of psychiatric diagnoses is different from making the claim that distress, manifest in myriad forms, is universal (Fernando, 2014; Mills, 2014).

In other words, psychiatric frameworks are mediators of that distress, they provide but one way of understanding, yet they are often framed as being the 'truth', worldwide. In this respect, Foucault (2008, p. 35-37), claims that "through certain power mechanisms, some knowledges are marginalized while others are legitimated as 'truth". Foucault argued that the knowledge shaped by discourses, empowered by institutions, and exercised through techniques and practices thus has the power to make itself true (Foucault, 2003, 2008, 2011). Foucault further argued that "discursive representations and practices `systematically form the objects of which they speak" (Foucault, 1972, p.49), actively constructing realities in specific ways, and normalizing particular forms of regulation and social control (Foucault, 2003). In this view, discursive practices produce identities, subject positions, and `institutional sites/ norms from which a person can speak or be addressed, as subjectivity is not conceptualized as coming from within, but rather as constructed within language and cultural practices (Foucault, 2003). Thus, representations of depression encapsulated within the DSM-5 (APA, 2013), ICD -11(WHO, 2022), not only define the boundaries of what it means to have a `depressed mind, but also function to construct the subject position `depressed person', legitimizing the right of particular experts to speak about and treat individuals' condition, and defining which particular `truths' are accepted as explanations for their 'disordered' state.

Similarly, as a ‘legitimated truth discourse’, ‘Western’ ideas about what constitutes depression as well as ‘appropriate’ treatments have become standardized, universalized, and traveled (Walker, 2008; Watters 2010; Summerfield, 2013; Fernando, 2014; Mills, 2014; Mills & Hilberg 2019) for the last two decades. This travelling is made possible at ground level by diagnostic and classificatory tools (such as the Diagnostic and Statistical Manual – DSM (APA, 2013), the International Classification of Diseases – ICD) (WHO, 2022) and GMH’s international intervention guidelines, which are translated so as to travel across geographical borders, signifying a “diagnostic creep” (Rose, 2006, p. 478). This understanding allows me to witness the ways in which facts never travel alone but are laden with subjectivities. As Berger and Luckmann (1966) write, “one must understand the social organization that permits the definers to do their defining. To put it a little crudely, it is essential to keep pushing questions about the historically available conceptualizations of reality from the abstract ‘What?’ to the socially concrete ‘Says who?” (p.116). It is through this process that people’s knowledge and beliefs about the world— all human knowledge, including science, “regardless of its ultimate validity or invalidity”— become legitimized in society, and the world can be said to be “socially constructed (Berger & Luckmann,1966).

Currently, depressive illness is considered the most common mental disorder throughout the world, and it is estimated to become the second most severe public health problem globally by 2030(WHO, 2017; Herrman et al., 2022). In this mainstream biomedical account, depression is positioned as a naturally occurring pathology existing within the individual, caused by biology, cognitions, or life stress, which can be objectively defined and measured (Braken et al., 2016). Within such framework, depression is deemed to be a discrete clinical entity that occurs in a consistent and homogeneous way, with identifiable aetiology factors, which are perceived to have caused the symptoms people report (Summerfield, 2008; Usher, 2011). A further problem within this bio-medical account of depression is that it reifies the construction of prolonged misery as a pathological disorder, ‘depression’, which negates the discursive context within which psychiatric diagnoses are constructed and expanded (Usher, 2011; Helen, 2011).

In the process, as Annemarie Mol (2001.p. 130), argue the ontology of depression has become practical. i.e., “What is, is not detachable of what is done”. And this conception has also historically justified. Because our time is arguably characterized by the conviction that something can and should be done about persistent sadness, low spirits, or feelings of nothingness (Angel, 2011).
Thus, numerous efforts to detect, control, and treat this “depression” have arisen out of such ‘therapeutic ethos’ (Helen, 2011). And the requirements of treatment from diagnosis to cure assessment determine how depression is conceived of and defined, i.e., what we consider depression to be is based on the idea of treatability (Hellen, 2011; Ingbly, 2014). Many are concerned about the potential for DSM 5 to over-medicalize normal life experiences (Frances, 2013; Horwitz & Wakefield, 2007, 2012; Kleinman & Hanna, 2013; Whitaker, 2010). More specifically, there is a concern that such constructs of human experience (for example, emotional distress, problems of living, conflicts in relationships and social suffering) as ‘mental disorder’ treatable by drugs (Bentall, 2010; Johnstone, 2000; Horwitz & Wakefield, 2007).

Similarly, controversy has also been sparked over the decision of DSM-5 to remove bereavement as exclusionary criteria for diagnosing depression within two months of a loss. One political take on this decision is that people now experiencing normal grief reactions risk being diagnosed – and treated with medication – for a major depression if they experience symptoms consistent with depression (i.e., crying, weight loss, poor sleep, reduced motivation, sleep changes, feelings of sadness….) for more than two weeks and that, importantly, there is inadequate scientific evidence to support this change. Moreover, the ability to accurately distinguish between what constitutes a major depression, as opposed to depressed mood, adjustment disorder and/or some other explanation; continue to haunt the DSM -5. Such an arbitrary process of medicalization, whereby subjective – and normative - experience are redefined as disease or needing treatment (Conrad, 2007; Horwitz & Wakefield, 2007; Hellen, 2011; Usher, 2011), illustrates the construction of knowledge, institutionalization, and legitimization of psychiatric treatment norms in the West (Berger & Luckman, 1966; Foucault, 2003). In addition to the arbitrary medicalization, some putative disorders may not be recognized as illnesses in other societies (i.e., grief as illness). Therefore, this dissertation investigated the notion of legitimization of the globalized psychiatric knowledge about depression and its circulation into LMICs.

Most categorizations of mental disorders and illnesses are composites of symptoms (Kirmayer et al., 2017; Kendler & Engstrom 2017). They adhere to traits socially decided to be undesirable and needing treatment (Jutel, 2009). Analyzing the construction of such discursive practices around such disorders can reveal the dominant ways in which the conditions are seen to be problematic and help to identify the social values contributing to the classification of a condition as an illness. Therefore, the analysis of biopolitics (Foucault, 2003, 2008, 2011) was employed as a conceptual tool to uncover the different "apparatuses" [biopolitical rationalities], (e.g., the epidemiological, ideological orders), and discourses endorsed in GMH and begin to shed light on what is meant by 'evidence', and what other evidence might mean for the practices of global mental health interventions for depression. To delve deeper into the workings of biopolitics, I examined how global mental health advocacy and WHO policies were employed as justifications for the implementation of psychiatric practices at a policy level. In essence, the study sought to understand the frameworks that may limit our perception and to identify potential alternative approaches to intervention. The significance of this analysis became apparent as I investigated how biopolitical factors may influence empirical realities. These considerations were integrated into subsequent chapters, with a particular focus on *Chapter 4 and 5.*

3.1.2 **Cultural-ecosocial Approach**

The cultural ecosocial view of mind, brain, and culture is concerned with shifting research and clinical practice from the emphasis on neurobiological processes that is currently dominant in North American psychiatry towards existential, social, and cultural predicaments as a central focus of clinical concern (Kirmayer, 2019; Go´mez-Carrillo & Kirmayer,2023; Go´mez-Carrillo etal., 2023b). Applied to global mental health, an ecosocial approach calls attention to the complex interplay between psychiatric disorders, health determinants, and illness experience, and their social and cultural embeddedness.-It acknowledges that human beings grow up and develop with in a society and specific cultures and their upbringing and learnt interactions define their behaviors that in turn affect brain structures leading to dysfunction (Kirmayer &Go´mez-Carrillo 2019; Ventriglio, Bhurgra & Gupta, 2016). Mental disorders are not isolated occurrences but are deeply embedded within specific social and structural contexts (Gómez-Carrillo & Kirmayer, 2023).

At the heart of this approach is the understanding that conditions of mental illness must be seen as engaging fundamental human processes—constituting an intricate mélange of culture, biology, and psyche, including self, emotion, cognition, gender, identity, and meaning (Jenkins, 2015; Jenkins &

Kozelka, 2017; Kirmayer, 2019; Gómez-Carrillo et al., 2023a). The main source of the argument is here is that social determinants play a major role – perhaps the major role in mental health. Culture and society shape the symptoms, course, and outcome of mental disorders (Jarvis & Kirmayer, 2021). Within this perspective, addressing mental health suffering requires developing solutions that focus on social change and transformations at different levels to enhance mental health wellbeing (Go ́mez-Carrillo &Kirmayer, 2023). For me as a researcher adopting this approach, this means considering how the topic of study is understood contextually, and working to foreground potentially under-considered contextual factors and structures that may be shaping distress in the Ethiopian context, including the wider socio-political contextual factors. It also means recognizing that individuals' narrative self-perception, culturally mediated interpretations of symptoms, coping strategies, and the responses of those in their social milieu all play substantial roles in the mechanisms underlying mental disorders, the experience of illness, and the journey toward recovery (Gómez-Carrillo & Kirmayer, 2022).

Integral to my engagement in studying depression in the space of global mental health is a commitment to understand and describe depression distributed along qualitatively defined continua, rather than being defined by discrete and distinct categories (Canguilhem, 1989). This means that in studying one of the most controversial mental health conditions of our time—depression, from a standpoint of lived experiences, there is no such thing as individual pathology. Instead, it is constituted by subjectivity where social, economic conditions, and the shaping of cultural expectations of a person play crucial roles. Hence, in a cultural-ecosocial approach to mental illness: (**1**) reality is culturally constituted, and (***2***) what is recognized as mental illness or affliction is influenced by culture. The assumption is that how we come to ‘know’ cannot be divorced from the discourses arising from social, cultural, and political elements operating at any given time and place of knowledge construction. This notion further acknowledges that an individual person, living in a particular historical and cultural context, with a particular set of life circumstances, and a particular set of beliefs and coping strategies, may come to experience distress. Yet, to consider that distress as an illness and set a standardized treatment, cultural and contextual understanding of that distress is required. Positioning research in such a way can provide insights into people’s experiences of ‘depression’ without seeking universal answers or universal solutions that deny the experiences of people across different social, cultural, or relational contexts.

3.1.3 Issues on Theoretical Positioning and Conceptualization

In this research, while I may question the direct 'travel' and veracity of the accounts of depression in the DSM-5 (APA, 2013), ICD-11 (WHO, 2022) or international guidelines such as mhGAP and argue that they should not routinely be applied to LMICs (with a focus on the Ethiopian context), I do recognize people's suffering, i.e., the social, economic, and political reality of suffering. Thus, while examined the biopolitical construction and circulation of global psychiatric knowledge and conception about depression and its establishment in LMICs and in Ethiopia, I aimed equally in exploring the depressive experience of people's suffering in context and going beyond the text to situate what will be said in a broader social, historical, and cultural context.

Thus, along with the biopolitical analysis of depression, I used a cultural-ecosocial approach to situate mental health and illness in a broader socio-cultural and political realm (Kirmayer, 2019). This approach allows us to acknowledge the 'real' of people's distress within a specific historical and cultural context. Instead of uncritically accepting and reproducing the dominant knowledge, the cultural-ecosocial approach legitimizes people's distress and challenges by keeping visible the clear links between the social conditions of people's lives and their suffering. For example, when there is inequality, poverty, or oppression, there is pain. Accordingly, a cultural-ecosocial perspective requires solutions that focus on social change and transformations at different levels to enhance wellbeing (Kirmayer, 2019; Gómez-Carrillo & Kirmayer, 2023).

3.1.4 Situating Myself as Researcher: "There Is No View from Nowhere"

Qualitative research places a high value on transparency and researcher reflexivity in both data collection and data analysis procedures. Methodological self-consciousness (Charmaz, 2017), or the scrutiny of the researcher's social location, is recognized as a crucial aspect of fostering reflexivity, along with an emphasis on social positionality (Harding, 1991). These principles align with a critical qualitative epistemology, which underscores that the researcher's approach and methods, much like the subject of study, are influenced by socio-cultural context (Levitt et al., 2021). Consistent with a critical stance (Guba & Lincoln, 1994), I believe that my values and lived experiences cannot, and should not, be separated from the research process. Rather, my values and experiences should be acknowledged as influencing my research interests, thesis topic, relationships with participants and the ways I view research and knowledge. Consequently, in this section, I begin by describing my background and how it has influenced my doctoral work and who I am as a researcher.

Throughout the interview and analysis process, I have diligently tracked my own expectations, reactions, and assumptions through journaling. However, I also recognize that my engagement with this topic is driven by personal and intellectual interests. My social location serves as the lens through which I perceive the world, and I maintain an awareness of the social and cultural capital that enables me to conduct this research. With past experience in qualitative research and a focus on the social determinants of health and mental health and illness, I have contributed to academic literature on the subject, critiquing methods and objectives of the MGMH. While this experience helps me to understand the depth of the subject matter and exploration, it also influences my research interest.

Positioning myself within the interdisciplinary and critical global mental health scholars, I oppose hegemonic, bio-reductionist, and universalist approaches to mental health that overlook social and systemic issues. Additionally, I do not identify as a person with lived experience of mental distress, hence positioning myself as an “expert” rather than an “expert by experience.” These power dynamics inevitably influence the direction and content of qualitative interviews, potentially amplifying certain topics while overshadowing others, and shaping the language used. In interviews, I strive to address these dynamics by acknowledging differences and posing questions to explore sensitive topics. However, my position and lack of lived experience may also impose limitations on my analysis. Moreover, having served as a senior lecturer and researcher at one of Ethiopia's top research-intensive universities for over a decade, my academic, research, and ethical commitments naturally influence my approach to the research topic.

So, what drew me to do this work? Looking back, my curiosities and comfort zones are as serendipitous as they are part of a biographical fabric that I continue to weave and redesign as I go through life and grow as a scholar. The path that has led me to the field of mental health and studying depression, however, began at a tender age when my elder brother died by suicide at the age of 32. While this traumatic incident changed my course of career and it also let me focus on researching more about the topic of depression and suicide: its essence, cause, and how it affects people’s lives. Engaging in personal and scientific research, pursuing advanced studies, and delivering lectures in Ethiopia about the subject of depression, I was still left with so many questions. My initial interest studying depression in GMH was rooted through this controversy. When I began my PhD, the debate was at its height and unfolded right within my academic networks. I was trained

to study any health concern in its socio-cultural and political contexts. GMH presented me with an epistemic and conceptual event(s) in which not only different notions of “mental health” collided but also different ways of knowing it. My interest in GMH therefore zeroed in on the conflicting conceptual and epistemic rules and objects mobilized in the debate, not on the merits of either side’s argument.

Born from a number of initially puzzling observations and immersing into the literature, I set out to study the production and circulation of “global” knowledge claims about mental health and illness and depression within the field of GMH and its implication in addressing depression in LMICs. In the most general terms, my dissertation therefore examines how a specific body of knowledge was constructed and mobilized in the re-making of space for psychiatric ‘subject peoples' in Ethiopia through (re)reading global mental health as a biopolitical discursive practice (Foucault, 2008). It further examines the local conceptualization of depression and how it aligned or diverged from the globalized definition or conception(s) as defined by DSM-5. In other words, I explore what a specific framework or ways of thinking about depression in GMH may hinder us from perceiving and what alternative approaches to intervention it might foreclose.

As such, my research traversed both geographical and epistemological distance, focusing on exploring the specific texture of GMH’s knowledge infrastructure. This involved examining how its actors reconcile the conflicting demands of generating comparable mental health "data" while also creating locally meaningful interventions. Second, my commitment to challenge the hegemonic narratives and advocating for a more critical, self-reflective, decolonized, and socially responsive discipline derives from my dedication to the GMH field. I see depression not just as a clinical condition but as a reflection of broader systemic issues that demands critical examination of GMH policy, research, and practice about depression in LMICs. Hence, my interest in critically studying depression in GMH emerged from my personal experiences, academic pursuits, and societal observations, each thread contributing to the pattern of my scholarly journey.

3.2. Research Design and Methodology

3.2.1 Research Methodology

The study employed an exploratory qualitative research design using an ethnographic inquiry approach to explore the conception of depression among patients diagnosed with depression and health care providers. Qualitative research aims to gain an in-depth understanding of the phenomenon under study (Denzin & Lincoln, 2008; Creswell, 2013). It usually seeks to capture people's perceptions [emic perspective], as they develop through their reality and the meaning, they attach to it (Creswell, 2013). Utilizing ethnographic methods, including informal conversations and in-depth interviews with individuals diagnosed with depression and healthcare professionals in Bahirdar City, the study aimed to uncover the specificities of the conception and responses to depression embedded within the experience of living in a particular cultural and contextual setting. Through this comprehensive exploration, the study sought to contribute to a more nuanced understanding of depression within the unique cultural context of Ethiopia, informing culturally appropriate mental health care and ultimately improving the well-being of sufferers. Based on these premises, an ethnographic approach was employed to answer the research questions, with a brief rationale and theoretical congruence discussed below.

3.2.2 Ethnographic Approach to Inquiry

Ethnography inquiry allows the researcher to explore and examine the cultures and societies that are a fundamental part of the human experience (Murchison, 2010; O'Reilly, 2012; Creswell, 2013). The goal of ethnography is then to gain insight into cultural and behaviour as well as cultural understandings and underlying thought process that produce behavior (Murchision, 2010; O'Reilly, 2012). Thus, ethnography research strategy can illuminate locally relevant understandings and ways of operating. In health care settings, for example, ethnography has been used to explore health beliefs and practices, allowing these issues to be viewed in the context in which they occur and, therefore, helping broaden the understanding of behaviours related to health and illness (O'Reilly, 2012). There is also a strong tradition of employing ethnography research method by medical anthropologists, cultural psychiatrists, and cross-cultural psychiatrists in researching the politics and practice of global health interventions (Hannah & Kleinman 2013; Bartlett, Garriott & Raikhel, 2014; Biehl & Petryna 2013; Storenga & Mishra; 2014). This body of research has demonstrated how medical systems can be best examined within larger historical, economic, and political contexts (Jenkins, 2015; Kleinman, 1977; 1980).

Therefore, ethnography research approach has been used to provide critical analysis of a phenomenon of investigation, for example, to study the politics of global health evidence production and research (see, Pigg, 2013; Lambert, 2013), and the discourses underpinning global health work (see, Lakoff, 2006, 2010, 2015), and its unintended consequences. Likewise, using an ethnographic method has provided an opportunity for this study to examine how particular processes – including biopolitics - operate within real-world settings (Whyte, 2009; Mills, 2014). The research was grounded in the recognition that 'exporting' the globalized concept of depression, primarily rooted in biomedical perspectives, onto LMICs, including Ethiopia, has the potential for problematic consequences. This imposition risked overlooking indigenous beliefs and cultural understandings related to mental health and illness, and it could undermine local coping strategies and non-biomedical responses to mental health challenges.

The study sought to unravel the complex dynamics of this process, acknowledging the need for a nuanced examination of the interplay between globalized mental health discourse and local contextual realities. In other words, health policy making in global health is a complex and multifaceted process that is influenced by a multitude of factors, ranging from scientific evidence and economic considerations to political ideologies and social values (Mills, 2014; Bracken et al, 2016). In the context of the Global South, where many nations face unique challenges in providing adequate healthcare for their populations, power relations play a crucial role in shaping health policies. These power relations, often driven by historical legacies, economic disparities, and geopolitical dynamics, exert a profound impact on the formulation, implementation, and outcomes of health policies in these regions (Kirmayer&Pedersen,14; Fernando,2014; Tribe,2014).

The domain of GMH introduces an additional layer of complexity to this discourse which demands a scrutiny. As such, applying this ethnography method to this study was thus much more than the use of a qualitative method. It is, as Lambert (2013) asserts, about questioning the categories that we take for granted, asking critical questions and interrogating, apparatuses, mechanisms, discursive practices (Foucault, 1977, 2003, 2008), about global mental health politics that shape the way we think about mental health and mental illness (i.e., depression) and questioning it's 'wholesale' travelling from one world region to another. Ultimately, ethnography method helped to situate

'depression' and those affected by depression in the larger sociopolitical context to seek solutions at the political or cultural level than considering depression as individual pathology.

3.2.3 Overview of Study Methods and Methodology

Study Setting

The research took place at two tertiary healthcare facilities situated in Bahir Dar, the capital city of the Amhara regional state in Northwestern Ethiopia. The city has a population of approximately 2 million people. Data collection was specifically carried out at two hospitals within Bahir Dar: Felege Hiwot Referral Hospital and Tibebe Ghion Specialized Hospital, both of which have played pivotal roles in global mental health initiatives, including the implementation of the Mental Health Gap Action Programme (MGAP) since 2008. The study benefited from the researcher's extensive networks derived from over 15 years of work experience as a university lecturer and public health and mental health researcher in the research setting. These well-established connections, combined with the researcher's Ethiopian nationality, deep familiarity with the region, and fluency in the national language (Amharic), facilitated trust and rapport with participants. Moreover, these qualities enabled her to discern sociocultural references and nuances in participants' responses effectively. It is also crucial to note the challenging context in which this research was conducted. The Amhara region has been significantly affected by an ongoing conflict since November 2020. As I write this dissertation, the Amhara regional state is under a state of emergency and have a physical war between the federal government and the regional government with significant social upheaval that has likely had repercussions on the mental well-being of its residents.

3.2.3.1 . Research Design

The study employed an exploratory qualitative research design using an ethnographic inquiry (Murchison, 2010; O'Reilly, 2012) approach to explore the conception of depression among patients diagnosed with depression and health care providers within the hospitals in focus. Utilizing ethnographic methods including conversation and in-depth interviews with people with mental illness (e.g., diagnosed with depression), and health professionals within Bahirdar City, the study aimed to discover the particularities of the conception and responses to depression as embedded within the experience of living in a particular cultural/contextual setting. By doing this comprehensive exploration, I aimed to contribute to a more nuanced understanding of depression within the unique cultural context of Ethiopia that can inform culturally appropriate mental health care in the country, ultimately improving the well-being of sufferers.

3.2.3.2 Participant Recruitment, Sampling, and Description

Although there is no general agreement about the process for selecting a sample and determining sample size among qualitative research scholars, Creswell (2013), and Morse (1994) recommended that 30 to 40 participants should be included for an ethnographic study in the clinical setting to understand the essence of a central phenomenon planned to be researched. Thirty-five in-depth interviews were conducted from June 2022 to July 2023, including 20 with individuals diagnosed with major depressive disorder (16 females, 4 males) and 15 with mental health care professionals (9 males, 6 females). Patients were purposefully selected from Bahirdar city and its surrounding areas, primarily from Felegehiwot Referral Hospital and TibebeGhion Specialized Teaching Hospitals. Patient were not hospitalized but they were diagnosed with depression with illness onset ranges from 3 months to 8 years. Participants were recruited based on self-reported, and were asked about their illness, their perceptions about depression, perceived causes, and their care pathways.

The fieldwork occurred in two phases: one from June to November 2022, and the second from June to July 2023. Conflict in the region informed the researcher’s decision to complete data collection in two short trips, rather than during one longer stay. The mental health care professionals interviewed included psychiatrists, integrated community mental health professionals, residents, and other mental health experts who were working at these two hospitals.

Inclusion Criteria: To select patients who are diagnosed with depression, the following inclusion criteria were employed: (a) older than 18 years (b) being diagnosed with depression according to self-report screening (c) residency in the Bahir Dar City and surrounding area. However, health care professionals were professionals who are formally trained physicians, nurses, psychiatrists, social workers, Integrated mental health care professionals, psychologists, and so on. The study invited mental health care workers at Felege Hiwot referral Hospital and Tebebe Gihon specialized Teaching Hospitals who :(a) hold a position as a clinical staff or a team member at the Psychiatric Unit and (b) provided psychiatric services at these hospitals.

3.2.3.2.1 Participant Recruitment Procedures

To access participants, publicity and self-identification were used as a primary mechanism of recruitment to recruit both categories of participants. First, the study was advertised in the public domain. All Study fliers were posted in common areas such as psychiatric care units, primary care

and specialty care health clinics and other areas freely accessible to the public. I left my phone number so that individuals who are interested in participating will contact me. Such publicity enabled me to (**a**) explain preliminary key issues regarding the study, such as what the study is all about and who would be eligible to participate, and (**b**) to appeal interested persons to communicate their willingness to participate in the study. In addition, all study fliers, recruitment scripts, consent forms, interview guides etc., were translated into the Amharic language (the national language of Ethiopia), and the native language of participants and the researcher. The following specific procedures were considered to facilitate the recruitment process for each category of participants:

3.2.3.2.1.1 Recruitment Procedures for Patients

Participants in this category were individuals with a history of depression who met the inclusion criteria. All patient participants were individuals diagnosed by psychiatric health workers as suffering from depression according to the DSM-5 (APA-2013). In this study, the exclusive use of publicity and self-identification served as the primary mechanisms for recruiting both categories of participants. Alternative recruitment methods, such as email for patients, were deemed impractical in the Ethiopian context due to limited internet and email access, as well as issues of technological accessibility. Consequently, email service was not a reliable means of contacting patient participants. The study's initiation involved publicizing it in various domains. Study fliers were prominently displayed in common areas such as psychiatric care units, primary care and specialty care health clinics, and other public-accessible locations. To facilitate participant contact, my phone number was provided on the fliers.

With the necessary consultations and permissions from hospital and psychiatric unit directors, study posters were displayed following approval from Western University and the Amhara Regional Public Health ethics board for recruitment purposes. This publicity strategy allowed me to (a) elucidate preliminary key aspects of the study, such as its purpose and eligibility criteria, and (b) encourage individuals interested in participating to communicate their willingness to take part in the study.

3.2.3.2.1.2 Recruitment Procedures for Mental Health Workers

Participants in this category included mental health professionals (e.g., psychiatrists, psychologists, physicians, social workers, psychiatric nurses and so on)– who work in Felege Hiwot and Tebebe Ghion Hospitals psychiatric units in Bahir Dar City. To enrol the psychiatric health workers, I advertised the study on notice boards at hospital Psychiatric Unit and public places. I left my phone

number so that interested participants will contact me. In addition, with the permission of the Hospital Director and the Head of the Psychiatric Unit, I arranged an orientation day at both hospitals to explain the key issues of the study, including the study's purpose, who would be eligible to participate, possible outputs, benefits. Then, I invited the mental health workers to consider participating in the study. This process helped to increase access to the participants in addition to the public advertising. Interested participants then were contacted an interviewed.

3.3 Data Collection Methods and Procedures

A combination of ethnographic sources of data such as in-depth interviews, informal conversations, observation, field notes and document analysis or collection of global or dominant discourses about depression, were used as a strategy to gather the relevant information to answer the research questions. However, in-depth interviews and document analysis were considered as the primary sources of data collection. Specific procedures for data collection are described briefly below.

3.3.1 In-depth Interviews

The interviews were designed to gain insights into how depression was reported and communicated among both patients and professionals, aiming to comprehend the nature of depression and the social ideas surrounding it. The focus was on exploring individual beliefs, understandings, and practices related to depression to attain a deeper understanding of how people in specific contexts conceptualize illness within their social and cultural worlds. During the data collection phase, special attention was given to how individuals articulated their experiences with depression, as well as their understanding of the disorder and responses to it including seeking help. All The interviews were conducted in Amharic, the national language of the country and the first language of the researcher at hospital setting All interviews were audio-recorded with the participants' consent. The primary sites for the study were two hospitals, and appropriate locations for interviews, such as interview rooms or boardrooms, were arranged through communication with the connect persons (psychiatric unit leaders and medical directors) at both hospitals to ensure a safe environment for the interviews.
In this study, one-to-one interviews were conducted and lasted approximately from 30 to 70 minutes. Participants were interviewed only once, and the interviews were designed to be convenient, allowing sufficient time for probing and gathering comprehensive information.

The interview guides were semi-structured, incorporating modified open-ended questions developed by Arthur Kleinman (Kleinman, 1988) to elicit patients' perspectives or explanatory models about their experiences with distress. For mental health care workers, the researcher developed interview questions focusing on understanding their perspectives on depression, including how they detect depressive illness during diagnosis, the expressions patients use to convey emotional distress, the instruments used for detection, and the challenges they face (see, ***Annex A and B for more detailed information. about interview guides).***

3.3.2 Document Analysis

In this study, document analysis served as one of the primary tools for data collection and analysis. The data category for this analysis includes selected international guidelines from WHO and the Global Mental Health (GMH) Movement, encompassing publicly available documents such as guidelines, policy documents, statements, and dominant discourses in GMH regarding depression. The WHO and the GMH Movement have developed these international guidelines with a focus on improving mental health services globally, particularly in Low- and Middle-Income Countries (LMICs). Definitions, management procedures, and biopolitical discourses were analyzed to understand the context and process of global mental health scale-up programs related to depression in the Global South. The main purpose of conducting the document analysis was to explore how international guidelines, such as the mhGAP-IG 2.0, function as part of "knowledge-power processes that inscribe and materialize the world in some forms rather than others" (Haraway, 1997, p. 7).

Documents were primarily selected from 2007 to 2023. The main rationale for focusing on document analysis during this timeframe is that the World Health Organization initiated a global call to address mental illness in its member countries in 2001, further reinforced by the global mental health movement launched in 2007 (WHO, 2012). This movement aligned itself with the World Health Organization's call, emphasizing the 'scaling up' of mental health services to LMICs, prioritizing mental disorders, including depression. The goal was to ensure access to the best and most effective modern psychiatric drugs and therapies (Collins et al., 2011; Mills, 2015). Since then, various standardized documents and health packages have been distributed to LMICs to address depression, along with mental, neurological, and substance abuse disorders (Limenih et al., 2023; Mills & Hilberg, 2019; WHO, 2016).

Thus, three main international guidelines implemented in LMICs to address depression were critically analysed (more detail in Chapter 5). The documents included were the WHO's mhGAP-Intervention Guide (mhGAP-IG) 2.0(WHO, 2016), Lancet Commission on Global Mental Health and Sustainable Development (Patel et al., 2018) and WHO's Depression Strategy (WHO, 2012). These three guidelines were selected due to their widespread implementation and extensive use as the primary conceptual framework, guidelines, and clinical tools for addressing depression within the GMH space. Notably, the mhGAP-IG Guide 2.0 (2016) serves as the central guideline currently being implemented in over 120 countries (Keynejad et al., 2019; Mills & Hilberg 2019; Limenih et al., 2024). In addition, mhGAP-IG is designed to provide a comprehensive resource for the identification, treatment, training, and education related to depression at the primary healthcare level in LMICs. Additionally, it has emerged as the primary clinical tool in the context of scaling up mental health services. Hence, the focus of the analysis was to examine how mhGAP-IGs serve as "inscription devices" (Latour &Woolgar, 1979. p. 63) in the wider quantification of mental health and depression, diverting attention away from their material processes of production and forming "the domains they appear to represent"(Rose, 1999.p. 198).

Hence, in this analysis, the mhGAP-IG was viewed as a culturally constituted object, aiming to highlight its conditions of production as well as its "social uses and consequences as a social phenomenon" (Rose, 2019. p. 72). A biopolitical discursive analysis was employed to analyze documents (Foucault, 2010). In its broader sense, "discourse' refers to all written, spoken, and other forms of communication. Foucault described discourses as "practices that systematically form the objects of which they speak" (Foucault, 2010, p. 49). Discourse analysis is the systematic study of discourse and its role in constructing social reality (Foucault, 2008). Using the Global South as an empirical site, I employed Foucauldian critical discourse and document analysis methods to explore how international guidelines, such as the mhGAP-IG 2.0, operate as part of knowledge-power processes that inscribe and materialize the world in some forms rather than others (Haraway, 1997). In this context, the Global North-Global South country classifications were used to contextualize power dynamics, acknowledge historical legacies, economic disparities, and power imbalances in global health policymaking and planning in the Global South.

Findings were discussed considering the historical, political, and cultural context, therapeutic implications, and the personal and social implications of how depression is understood. Several

resistive discourses, ideological in character, were identified and the analysis concludes by suggesting a reconceptualization of the treatment gap for common mental disorders. Detailed findings are reported and published (*see, Chapter 5).* The analysis, however, did not provide an extensive overview of global mental health and WHO policy analysis. Instead, it focused on exploring specific knowledge mobilizations within these policies, creating a map of some of the 'biopolitical rationales' to understand how different ways of thinking may align and what alternative frameworks they may conceal. The study then further to explored what is meant by ‘evidence', and what other evidence might mean for the practices of global mental health. In the research process, however, no specific encounters or accounts were privileged over others; for example, interview extracts, WHO policy, ethnographic field notes appear alongside each other, horizontally.

Data Analysis Methods and Procedures

Primary data collection and analysis occurred simultaneously (Murchison, 2010; O’Reilly, 2012). Initially, I conducted open coding to identify key words, phrases, and themes. Then, interviews were categorized into conceptual domains (O'Reilly, 2012). Thematic analytic process involved three fundamental stages to identify and advance understanding of key conceptual domains. Firstly, there was data preparation: In this initial phase, the raw data was gathered, organized, and prepared for analysis. Secondly, recordings were transcribed verbatim in Amharic. Subsequently, the data was analyzed in Amharic to maintain the authenticity of the findings. Finally, the summary of the analysed data was translated back into English. Quality was ensured by comparing transcripts with audiotapes. Then, I conducted the detailed analysis. In this initial stage, I reviewed and revisited the transcripts, generating preliminary codes using Open Code. In the second stage, I familiarized myself with the data by both listening to the audio recordings and re-reading the transcripts. This involved a pattern recognition and coding segments of data and grouping them into meaningful categories. During this phase, analytical ideas that emerged during data familiarization informed the re-review of the preliminary codes. This iterative process involved refining the codes, selecting those most pertinent to our research questions, and making sense of the data based on patients' explanatory models and in dialogue with the rest of the author team. The third stage was theme development and an in-depth analysis to ensure that the combined codes harmonized well with the collected data and remained aligned with the study's objectives. Special attention was given to Amharic terms. As a result, when necessary, Amharic words and their English translations into the finding were included. Results are presented as integrated articles (see, Chapters 5,6,7,8 for detailed findings).

Ethical Considerations

The study was approved by the Western University Health Sciences Research Ethics Board (HSREB) (**Ref**:2023-122473-79368) and Amhara Public Health Regional Institute Ethics Board (EPHE) at Bahirdar city (**IRB ref**: NoH/R/T/T/D/07/53). All interviews were conducted after obtaining written informed consent from participants. No identifiers were used during the interviews while transcribing to maintain the privacy of the participants. Participation in the study was voluntary, and participants knew they could decide at any point to opt out. The participants provided both verbal and written informed consent during the interviews. For detailed information about the letter of information and the consent process, please refer to *Annex-A*

3.4. Limitation(s) of the Study

It is important to acknowledge methodological limitations. I interviewed patients diagnosed with depression at a health facility, which may have biased responses toward the biomedical model and may also speak to the severity of symptoms. Different responses might have emerged in a more familiar location, such as their homes. Furthermore, the findings were limited to individuals with depression and mental health care professionals. Including individuals without such experiences and the broader community could lead to more robust results regarding the conception of depression. It is also crucial to note the challenging context in which this research was conducted. The Amhara region has been significantly affected by an ongoing conflict since November 2020. As I write this dissertation, the Amhara regional state is under a state of emergency and have a physical war between the federal government and the regional government with significant social upheaval that has likely had repercussions on the mental well-being of its residents. As such, the ongoing war during the data collection period constrained the duration of data collection, thereby limiting the number of accessing the participants and depth of data acquisition.

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Chapter 4

4 Biopolitical Analysis of Depression in Global Mental Health

While there is significant diversity and contestation within Global Mental Health (GMH) and the Movement for Global Mental Health (MGMH) a key "condition of possibility" shaped their emergence: the availability of data on the prevalence and burden of mental disorders worldwide, contrasted with the low number of available professionals and resources for mental health across countries (Saxena & Belkin, 2017). These metrics have been central in making visible and constructing the idea of a "treatment gap" (Collins et al., 2011)—a core issue GMH seeks to address (Mills, 2018)—and in exposing the lack of available mental health care as a "hidden emergency" (Funk & Van Ommeren, 2010). GMH and MGMH frame the failure to address this emergency as a "failure of humanity" (Kleinman, 2009), which sets up a moral call for action founded on a quantified notion of the scale of the "problem," with "scaling up" poised to be a key solution.

GMH practice aims to include a wide range of interventions and not rely on drug prescription alone, but medication delivery does play an important role in many GMH programs. However, psychopharmaceuticals have limited efficacy, significant adverse effects, and can themselves be used in ways that limit freedom and violate human rights (Crawford et al., 2014; Greenberg, 2010; Kirk et al., 2013; Lacasse & Leo, 2015; Whitaker, 2010). In this biomedical account or "technological paradigm'' (Bracken et al, 2012. p .430), depression is positioned as a naturally occurring pathology existing within the individual, caused by biology, cognitions, or life stress, which can be objectively defined and measured. A further problem within this account of depression is that it rectifies the construction of prolonged misery as a pathological disorder, 'depression', which negates the discursive context within which psychiatric diagnoses are constructed, expanded, and disputed (Kawa &, Giordano, 2012; Frances, 2013) (see the detailed analysis below). Therefore, the promotion of depression as an illness like any other in GMH can serve as an "apparatus" for the (re)production of subjectivities (Foucault, 1980; 2003, 2010).

Because this perspective tends to individualize, pathologize, decontextualize, and emphasize personal responsibilization (Foucault, 2010; Rose, 2007, 2009). At the same time, such ways of thinking and practicing mental health prevent alternative frameworks or broader solutions and it also creates conceptual voids that reproduce inequity and oppression and subsequently produce an

‘epistemic injustice’ for speaking about and coping with depression in the LMIC context (Fricker, 2003; Santos, 2014).

Foucault in his later works focused on knowledge, biopower, and discipline and their inter-relations, which operate through the mechanisms of discourse or discursive practices. A discursive practice according to Foucault is "the process through which [dominant] reality comes into being"(Foucault, 2003). The management of life, which Foucault refers to as ‘biopolitics’ is performed through a variety of means and techniques, practices, and procedures that are aimed at organizing, regulating, and governing the phenomena peculiar to life in the context of society and the larger population (Foucault, 2003, 2010). Foucault further argued that the knowledge shaped by discourses, empowered by institutions, and exercised through techniques and practices thus has the power to make itself true (Foucault, 2003, 2008, 2011). Foucault claimed that power is irrevocably connected to knowledge, which in turn has a regulatory function, for example, through categorizing what is normal and abnormal, what is `mad' and what is `sane’ (Foucault, 1965, 1980).

Foucault argued that “discursive representations and practices `systematically form the objects of which they speak” (Foucault, 1972, p.49), actively constructing realities in specific ways, and normalizing a particular form of regulation and social control (Foucault, 2003, 2011). In this view, discursive practices produce identities, subject positions, and institutional sites/ norms from which a person can speak or be addressed, as subjectivity is not conceptualized as coming from within, but rather as constructed within a language and cultural practices (Foucault, 2003). Thus, representations of depression encapsulated within the global standardized WHO guidelines, policies and GMH packages of care not only have the potential to define the boundaries of what it means to have a `depressed mind’, but also function to construct the subject position `depressed person’ and defining which particular `truths’, are accepted as explanations for their ‘disordered’ state.

Similarly, as the only legitimate truth discourse (Foucault, 1972), ideas about what constitutes mental illness as well as ‘appropriate’ treatments have become standardized, universalized, and traveled from the HICs to LMICs for the last two decades. This travelling is made possible at ground level by the WHO standardized international guidelines (WHO, 2008; 2010, 2013, 2021) and ‘packages of care’ (Patel &Thornicroft, 2009) which are translated to travel across geographical borders, signifying a “diagnostic creep” (Rose, 2006, p. 478). Because to claim the universality of depression

as a ‘brain disease’ or ‘debilitating disease’ is different from claiming that distress, manifest in myriad forms, is universal (Bracken et al, 2016; Haroz et al., 2017; Lewis-Fernandez, & Kirmayer, 2019).

From the start, as many scholars have noted, and I discussed in the above sections, the global data on the prevalence of depression in specific settings around the world (LMICs) are far less robust than acknowledged in the promotion of GMH as morally necessary (Brhlikova et al., 2011; Baxter et al., 2014; Ecks, 2021; Summerfield, 2006, 2008, 2013). Without accurate estimates of disorder prevalence or the number of people who receive treatment for depression, the current estimates of the treatment gap can be viewed as no more than an approximation of the need for care. GMH programs, however, assume a massive ‘treatment gap’ in LMICs for depression. Global mental health interventions have, thus, become a matter of ‘‘scaling up,’’ before calling for an investigation into the appropriateness of using standardized diagnostic categories of depression as the basis for measuring need and providing expanded access to care. This perspective still assumes that the prevalence of depression can be objectively measured, and mental illness can be tackled by a unified strategy throughout the world. This is happening even though there is no such global consensus existing on these premises (Bracken, et al., 2016; Borsboom, Cramer & Kalis, 2019; Haroz et al., 2017).

But numbers are usually political, and they are mobilized in the service of moral objectives. As Starr, (1987) stated, while “the characterization of people is myriad and subtly varied, statistical systems reduce complexity, incorporating this myriad into a single domain, and very often generating a single number that will appear in headlines, in speeches, and the reports” (p. 40) (emphasis added). According to worldwide projections from the WHO, by 2030, the amount of disability and life lost from depression will surpass that from war, accidents, cancer, stroke, and heart disease (WHO, 2012, 2017, 2022). Such statements serve as a moral imperative to make depression universal and globally visible or demanding attention. Paradoxically, simultaneously depoliticizing depression makes it appear as simply a recognition of objective reality—a universally acknowledged illness.

Taking a cue from Foucault, who suggests analyzing the formation of universals through specific practices (Foucault, 1980, 2010), I have come to ask how global mental health actors apply universals to the 'real world' in the LMICs to address depression. The point of departure for my analysis was to show how GMH which is based on problematic assumptions, international guidelines can serve as an apparatus made up of "strategies of relations of forces, supporting and supported by, types of knowledge" (Foucault, 1980.p. 196). I viewed global mental health as a global assemblage through which new types of personhoods emerge (Hacking, 1999, 2002). In this assemblage, many global institutions work to exclude statements that they view as false or simply 'unscientific' and keep circulating those statements they characterize as 'true'. But as this dominant discourse (biomedical account of depression) is promoted as a universal standard and a global norm, other ways of knowing about depression are silenced or forced to speak in whispers.

My analysis does not aspire, therefore, to argue 'for' or 'against' the aspirations of GMH. Instead, it aims to ask what a particular framework or ways of thinking about depression prevent us from seeing, and what alternative ways of intervening they might foreclose. Below, I conducted a critical analysis of some inherent paradoxes of depression in GMH policy and practice in LMICs and explore their unintended consequences. This sets the dissertation in a sufficient context and establishes a foundation for the subsequent analyses, particularly chapter 5. To explore the treatability discourse of depression in GMH, I start my engagement with an uncomfortable but crucial question: what are we 'scaling- up'?

4.1. Depression, The Treatability Discourse in GMH and Its Discontents

The current urgent need for addressing the 'treatment gap' for depression in the LMICs or the treatability discourse is historically justified. Because our time is arguably characterized by the conviction that something can and should be done about persistent sadness, low spirits, or feelings of nothingness (Angell, 2011a), numerous efforts to detect, control, and treat 'depression' have arisen out of such therapeutic ethos (Healy; 2004; Greenberg, 2010; Rosenberg, 2019). Drugs are now marketed to help people who are simply shy, anxious, and sad, as well as for those who simply want to become more assertive, emotionally stable, or popular (Angell, 2011).

The requirements of treatment, from diagnosis to cure assessment, determine how depression is conceived of and defined, i.e., what we consider depression to be is based on the idea of treatability (Horwitz & Wakefield, 2007, 2012; Whitaker, 2010). Most importantly, as Martin (2007) notes, "movement toward thing-like status makes mania and depression seem possible to identify, manipulate, and optimize through the technology of psychotropic drugs and taxonomic apparatuses" (p.220) (emphasis added). Because of this treatability discourse about depression, the boundaries of depression have been extending relentlessly (Shorter,1997). In recent years, there has been a strong tendency to over-pathologize mild to moderate forms of depression (Greenberg, 2010; Healy, 2004; Horwitz & Wakefield, 2007, 2012; Moncrieff, 2014).

Critical psychiatry literature and leading figures in psychiatry like Allen Frances (2013, a, b) and many others have documented evidence about the problem of diagnostic inflation, including labeling prolonged grief and sadness as depression (Horwitz & Wakefield, 2007); extending bipolar disorder (BD) to cover a broad spectrum of mood variations and applying the diagnosis to adolescents, children, and even infants (Moncrieff, 2014; Paris, 2012); and treating shyness and other variations in social behavior or gregariousness as anxiety disorders (Horwitz & Wakefield, 2012). In high income countries (HICs), there are also growing concerns about the proliferation of psychiatric diagnoses, overuse of medications, and the medicalization of everyday problems in living (Frances, 2013). Claims that more than 63 percent of the population suffer from mental disorders have led prominent psychiatrists and psychologists to worry that we are losing the very notion of "normal" (Frances, 2013).The prolonged expansion of drug-intensive psychiatric practices, the therapeutic value of psychoactive drugs, and the strength of their evidence base remain controversial, even in HICs (Healy, 2004; Greenberg, 2010; Lacasse & Leo, 2015; Whitaker, 2010).

Along with the rise in numbers of diagnostic categories and rates of diagnoses has come a dramatic increase in prescriptions for and consumption of psychiatric medications. This trend is reflected in the increased use of prescription psychoactive drugs (Healy, 2004; Rosenberg, 2019; Whitaker, 2010). Studies show that extreme marketing of antidepressants over recent decades has resulted in a dramatic rise in their use, and in the widespread acceptance that depression is caused by a chemical imbalance that can be rectified by drugs (Greenberg, 2010; Healy, 2004; Leo & Lacasse, 2008; Moncrieff, 2009, 2014). This situation led Nikolas Rose (2004) to conclude that a large proportion of people have come to ''recode their moods and their ills in terms of their brain chemicals'' (p. 15).

Contrary to this public belief, it has not been shown that depression is associated with an abnormality or imbalance of serotonin or any other brain chemical, or that drugs act by reversing such a problem (France, Lysaker, & Robinson, 2007; Moncrieff & Cohen, 2006; Moncrieff, 2009). Meta-analyses of clinical trials have also revealed that in general, antidepressants were little more effective than placebos for mild to moderate depression (Kirsch et al., 2008; Kirsch, 2010, 2014, 2015; Lacasse & Leo, 2015; Kirmayer, Lemelson & Cumming, 2015). While treatment availability has increased significantly in HICs, there is little evidence that people's mental health in these settings has improved. If there is one clear pattern over the past decades, it has been a substantial increase in the use of psychopharmaceuticals with no reduction in the prevalence of depression, mood, anxiety, or substance use disorders in any high-income country (Jorm et al., 2017; Moore & Mattison, 2017; Pratt, Brody, Gu &2017).

Without solving this dilemma, the WHO and GMH movement still aim to ensure that people around the world must have access to the same treatment available in HICs to address depression. This also points to a strange irony at work in GMH, as the therapeutic crisis of depression has been highly criticized in many HICs, with some asking for a paradigm change (Bracken et al., 2012) due to its controversial evidence base (Summerfield, 2008; Ingleby, 2014). When the strategies to address depression in LMICs are continuously shaped and framed by the same psychiatric intervention currently facing enormous critique in HICs, it leads me to raise three fundamental concerns: (***1)*** what constitutes the 'evidence' base of GMH and who decides what counts as evidence? (***2)*** what are the ethics of 'scaling up' treatments for LMICs whose efficacies are still hotly debated within the global North? and ***(3)*** what kind of mental health system and care we are envisioning for the LMICs? In the face of such critiques, continual calls for scaling up of GMH interventions for depression that continue to be justified based on the rhetoric 'urgency' underlying GMH's 'epidemic' approach to human suffering, and that continue to prioritize funding for access to drug-based treatment, are problematic.

People all around the world suffer from distress, but whether mental illness is best labeled as an individual mental health disorder/illness, or whether a drug remedy can be the best solution is questionable (Kirmayer & Crafa, 2014; Jenkins, 2015; Jenkins & Kozelka, 2017). This strategy in reducing mental ill-health may create an ethical lapse and cross the line between science and marketing. There is a continual promotion of drug-based intervention statements by WHO (2012),

for example, “unlike many large-scale international problems, a solution for depression is at hand. Efficacious and cost-effective treatments are available to improve the health and the lives of the millions of people around the world” (WHO, 2012. p.8).

Many people in LMICs undoubtedly might experience forms of mental distress but most of these arise from experiences of adversity such as warfare, conflict, poverty, and inequality (Lund et al., 2011; Rose, 2019), many forms of these forms of adversity can and should be tackled directly, without the need for individualized diagnosis requiring treatment. But the development of more psycho-pharmaceutically-centered services is not an efficient or even desirable answer. Instead, it demands more committed social health interventions, guided by outcomes that are not measured in terms of symptom reduction but the capacities that people desire in their everyday lives.

GMH advocates for the human rights of mental health sufferers, which I agree is essential but continues to fold and blur with the focus on access to drug-based treatment based on diagnostic categories whose relevance across diverse cultural settings has not been empirically established. In practice, however, this also means that offering explanations that do not fit well with local understandings or that undermine interpretive systems that are associated with coping strategies, healing practices, social support, and integration (Pederson & Kirmayer, 2014). GMH policies and strategies now face an inherent paradox as the efforts to scale up practice require an assumption that standardized interventions will work across contexts. I have argued that the same human right that motivates the efforts to achieve equity in global mental health should also underwrite the protection of social space where people can live out their cultural lifeways. GMH, as a body of knowledge, social institution, and form of clinical practice, it is a product of cultural history which has a significant influence on the contemporary culture of clinical and public health practice (Pederson &Kirmayer, 2014). The rise of psychiatric epidemiology (Lovell & Susser 2014) and the international harmonization of disease classification through the WHO, both contributed to the possibility of ‘‘global’’ claims about ‘depression’ despite ongoing contestation (Bracken et al., 2016; Bemme & D’souza 2014; Ecks, 2021; Summerfield, 2008; Mills, 2014).

Dazzled by the current global avalanche of numbers, and claims about depression, it is pertinent to ask and examine the social life of numbers, and epistemic inclusions and exclusions by asking ‘‘What counts as knowledge?’’ and ‘‘Whose knowledge counts?’’ in global mental health (Adams 2016; Feranado, 2012; Summerfield, 2012; Wendland, 2016, 2018). For example, much of the call to scale up mental health services assumes that there is a treatment gap and a high need for mental health services for depression and that this is not being met. In the GMH literature, this seems to imply that current services and resources for addressing depression in LMICs do not exist and that what does exist is inadequate, ‘unscientific’ or people do not have adequate knowledge about it. Such assumptions are problematic.

The GMH advocates, notably, Patel, Boyce et al (2011) became oblivious when they stated that to address the treatment gap, “the mhGAP guidelines should become the standard approach for all countries and health sectors; irrational and inappropriate interventions should be discouraged and weeded out” (p. 1442). This led me to ask a critical question that is at once practical and epistemic: is it possible to share a world where different ways of knowing that world can coexist and complement one another? Such a narrative fails to recognize the different ways of knowing by which people throughout the world provide meaning to their existence or define selfhood (Kleinman, 1977, 1980). The dominant discourse is closed to epistemological diversity through the telling of a single story that claims to be universal. This hegemonic thinking continues to display an implicit hierarchical assumption that disregards local and indigenous knowledge on many grounds.

One of the longstanding areas of disagreement in GMH has been the lack of recognizing the relevance of local knowledge, which may include different and alternate sources of authority, methods, and standards for evidence (Kirmayer, 2012, 2019). It has been long argued that the relevance of mental health outcome measures should reflect a ‘‘pluralistic view of knowledge’’ (Kirmayer & Swartz, 2013), that recognizes multiple voices and sources of knowledge and avoids “epistemic injustice” (Fricker, 2003; Santos, 2014). Achieving epistemic justice requires creating a space that is open to diverse perspectives and acknowledges that mental illness and pathways to mental health are defined differently worldwide.

Most significantly, the category of depression is produced in historically contingent ways through a range of professional practices that seek to identify and know abnormal behavior through the clinical gaze (Foucault, 2009(1965); Jackson, 2008; Kendler & Engstrom, 2017; Shorter, 1997). GMH policies which are based on a discursive conceptualization of depression produce what I call the architecture of depression through different ‘‘apparatuses’ [dispositifs]” (Foucault, 1976. p. 242-243). For Foucault, (1976) “an apparatus is a texture of entwined discursive and extra-discursive practices – however heterogeneous – that articulates itself in the forms of what we could define as an acted-out knowledge” (p. 243). In other words, an apparatus is a mechanism, which makes some things more visible. It is also a system of power relations internal to the ‘making’ and its typical function is to respond to the perception of an urgent need.

GMH's current initiatives promoting the biomedical notion of depression along with its "inscription devices" (Latour &Woolgar, 1979. p. 63) such as mhGAP guidelines, thus, serve as an apparatus that operates as a ‘strategic response’ to the contemporary ‘urgent need’, the global ‘emergency’ and ‘epidemic’ of depression; they act to make depression an illness like any other. Such promotion of depression as an illness like any other produces the architecture of depression in LMIC societies that will lead to unintended consequences. In most LMICs, ‘depression’ is not usually considered an illness or exclusively as a medical problem. Instead, it is often negotiated within the sociocultural contexts, norms, and ways of social functioning (Haroz et al., 2017; Kirmayer et al, 2017; Osborn, Kleinman & Weisz, 2021; Tekola et al., 2023).

The following chapter (i*.e., chapter 5*) presents the detailed implications of this framework of depression within the domain of GMH policy and discourse in LMICs. Using the Global South as an empirical site, an extensive document analysis and biopolitical discourse were conducted, revealing various ideologically driven biopolitical rationalities.

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Chapter 5

5 Depression and Global Mental Health in the Global South: A Critical Analysis of Policy and Discourse[2]

5.1. Introduction

> 1 billion people globally are estimated to be living with a mental disorder, 81% of whom live in low-income and middle-income countries. Among this one billion, 5% of adults have depression, making it a leading cause of disability, and a major contributor to the overall global burden of disease (Hermman et al., 2022. p. 885).

How we frame and define a mental health problem influences how we respond to it. Depression has been framed as a severe global public health crisis (Hermman et al., 2022). As well, mental health is predicted the greatest international disease burden in 2030 and be a primary cause of avoidable suffering and premature mortality (Hermman et al., 2022; Chisholm et al., 2016). Estimates of the global burden of depression in terms of disability, quality of life, and economic impact have also been used to argue for scaling up the detection and treatment of depression as a public health and development priority in low- and middle-income countries (LMICs) (Chisholm et al., 2016).

The Movement for Global Mental Health (MGMH) and the World Health Organization (WHO) have prepared a series of standardized international intervention guidelines and health packages to address depression in LMICs. These could improve care and treatment for depressive illness along with other mental, neurological, and substance abuse problems (MNS) to close "the treatment gap" (Collins et al., 2011). The *treatment gap* refers to the percentage of people who meet the diagnostic criteria for a specific disorder but do not receive treatment (Collins et al., 2011). This has been a fundamental tenet of GMH, which was built on two major assumptions: 1) mental disorders are extremely common; 2) mental health services are scarce worldwide, but the gap is particularly wide in LMICs (Collins et al., 2011; Chisholm et al., 2007).

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The proposed enormous level of unmet need for care has led to calls to "scale up" mental health services globally as a central priority in the field of global mental health[4] specifically to address mental health issues in LMICs. The Lancet GMH series of 2007 and 2011(Chisholm et al., 2007; Patel et al., 2011) have argued that the field's central mission is to scale up "evidence-based" care to "close the treatment gap" for mental disorders, the most common of which are common mental disorders (CMD) (i.e., depression, anxiety, and somatoform disorders). These arguments are echoed in key WHO publications that put "closing the treatment gap" and expanding access to mental services at the forefront of its international mental health policy and the development of a series of Mental Health Gap Action Programmes(WHO, 2008, 2013, 2016a, 2016). As we write, the latter programme has now been implemented in over 100 countries (Keynejad et al, 2018; Mills & Hilberg, 2019).

The intervention guides, such as the WHO's mhGAP-Intervention Guide (mhGAP-IG) 2.0 (2016), are "evidence-based tools" and guidelines to help detect, diagnose, and manage the most common mental disorders (WHO 2016a, 2016). Practical concerns like how the programs can be used to advantage in culturally different settings and populations remain. The ubiquity of 'treatment gap' statistics as a framework for assessing unmet needs largely demonstrates the pervasiveness of this paradigm in global mental health about depression. For example, the most recent global gap report in treatment coverage data for major depression in 84 countries suggest only eight percent of adults in LMICs who meet diagnostic criteria for depression use services for these symptoms (Moitra et al., 2022). Similar figures appear in almost every global mental health research article, policy document and advocacy initiative about the depression treatment gap (Hermman et al., 2022; Chisholm et al., 2016; WHO 2016a; Moitra et al., 2022). It is unclear whether this reflects a limited supply of mental health services or a lack of demand for medical intervention for these experiences. There has been much critique of the evidence base used to establish and describe the mental health treatment gap. This includes critique that raises concerns about the dangers of exporting a Western model of disorder and treatment, ignoring cultural variation in understanding, responding to social suffering, and lead to medicalizing distress (Mills, 2014; Ingleby, 2014).

Prominent scholars in the field of critical psychiatry have issued a call for a comprehensive re-evaluation of efforts to expand mental health diagnoses and treatment in Low- and Middle-Income Countries (LMICs). These initiatives have been formulated and implemented under the assumption that Western biomedical categories and treatment methods can be universally effective on a global scale (Mills, 2014; Summerfield, 2006, 2013; Bracken et al., 2016). Several scholars have also questioned the validity of standard depression diagnostic instruments, the reliability of global prevalence estimates, and the applicability of GMH's international programmes in LMICs (Mills, 2014; Summerfield, 2006; Bracken et al., 2016; Ingleby, 2014; Ecks, 2013; Ecks, 2021).

Critics stressed that GMH ignores significant local variation in conceptualizations of mental distress and depression and diverts attention away from the social and economic determinants of illness (Bracken et al., 2016; Summerfield, 2006, 2013). Because of this, there has been a widespread call to tailor interventions to local cultures, local health care systems, and specific populations (Kirmayer &Pedersen, 2014; Ecks, 2013; Kirmayer & Swartz, 2013). Another line of critique relates to the de-contextualization of suffering. Mills (2014) argues that translating situated accounts of suffering into context-free psychiatric diagnoses involves abstracting symptoms from their personal and social context and framing problems as brain-based disorders rather than a sign of disruption in a person's "lifeworld," that is, those experiences, activities, and social networks that make human life meaningful (Lewis-Fernández & Kirmayer, 2019). This article inserts itself within and expands upon calls to reconceptualize the treatment gap for common mental disorders like depression via document and discourse analysis.

In response to the mob of critics, the Lancet Commission (Patel, 2018) replaced 'treatment gap' with the "care gap" (Patel et al., 2018, p.122), referring to the unmet mental health, physical health, and social care needs of people with mental illness, including depression (Pathare et al., 2018). However, it can be argued that maintaining the notion of a "care gap" still misses a more fundamental point in the understanding of depression across LMICs: why do so few people in these settings access mental health treatment for depression? Moreover, how does the assertion of a mhGAP influence how we conceptualise solutions to the lack of service uptake? And how do we know there so many people in LMICs who have been suffering from "depression," creating the demand for more programmes of depression awareness for professionals and the public or laypersons alike?

In this article, we critically examine the construction of global mental health policy and practice in LMICs which is heavily influenced by mental health treatment and care gap discourses. It is our argument that the continual framing of mental health problems in individual terms continues to obscure the role of wider determinants of mental health and encourages the provision of clinical interventions rather than public health approaches (Kirmayer & Pedersen, 2014). Our critical interrogation takes its cue from Foucault. Using Foucault, we propose that historically specific GMH assemblages make existing assertions about the mhGAP possible, while shaping the global discourse about depression through their (re)production of biopolitical assumptions and impacts, governmentality, and "conditions of possibility" (Foucault, 2008, 2010). It is our assertion that mhGAP, works as part of "the knowledge-power processes that inscribe and materialise the world in some forms rather than others" (Haraway, 1997, p. 7) and allows for certain understandings of mental health to be more accessible than others.

Our analysis begins by analysing the 'conditions of possibility' and context within which the mhGAP-IG is developed and circulated. We then consider an often-overlooked contributor to the depression treatment gap discourse: 1) low demand for services because of non-medical interpretations of depression and related experiences, 2) implications for how we respond to the needs of people who are thought to be depressed. Ultimately, this exploration aims to uncover the ways in which current dominate discourses about depression in GMH and the mhGAP work to produce and limit possibilities of concern and care for mental health in LMICs, by defining only certain forms of personhood and suffering as legible.

5.2. Methodology

Discourse Analysis: Our analysis is based on biopolitical discursive analysis (Foucault, 2008, 2010). In its broader sense, 'discourse' refers to all written, spoken, and other forms of communication (Foucault, 2010). Foucault described discourses as "practices that systematically form the objects of which they speak." Discourse analysis is the systematic study of discourse and its role in constructing social reality (Foucault 2010, P.49). As Maes stated, a useful approach to exploring insider critique within GMH is to engage in "studying up," (Maes, 2015, p. 55) that is, using critical ethnographic methods of researching. Hence, this current analysis is part of a broader research study that examines global mental health, biopolitics, and depression in the Ethiopian context through an ethnographic method of inquiry. The category of data for this analysis includes selected WHO's

publicly available international guidelines, policy documents, and the dominant discourses in GMH about depression.

Thus, three main international guidelines implemented in LMICs to address depression were critically analysed (more detail below). Definitions, management procedures, and biopolitical discourses (Lewis-Fernández & Kirmayer, 2019) were analysed to understand the context and process of global mental health scale-up programmes about depression. However, the focus of the analysis is to examine how mhGAP-IGs serve as "inscription devices" (Latour & Woolgar, 1979, p. 63) in the wider quantification of mental health and depression, diverting attention away from their material processes of production and forming "the domains they appear to represent" (Rose, 1999. 198). Hence, in this analysis, the mhGAP-IG is viewed as a culturally constituted object, aiming to highlight its conditions of production as well as its "social uses and consequences as a social phenomenon" (Rose, 2019, p. 72).

We selected these three guidelines due to their widespread implementation and extensive use as the primary conceptual framework, guidelines, and clinical tools for addressing depression within the GMH space. Notably, the mhGAP-IG Guide 2.0 (2016) serves as the central guideline currently being implemented in over 100 countries. It provides a comprehensive resource for the identification, treatment, training, and education related to depression at the primary healthcare level. Additionally, it has emerged as the primary clinical tool in the context of scaling up mental health services. We also utilized the Global North-Global South country classifications to contextualize power dynamics, acknowledge historical legacies, economic disparities, and power imbalances in global health policymaking and planning in the Global South.

5.2.1 Analyzing Documents: Discourses and Technologies of Rule

The mental health gap guidelines are multiple—practiced and done (talked about and used) differently in different contexts (Mills, 2014; Mills & Hilberg, 2019) and these differences are analytically important. The three main documents that are the focus for this analysis illustrate several dominant narrative discourses that are ideological in character. The first of these, the WHO's mhGAP-Intervention Guide (mhGAP-IG) 2.0 (WHO, 2016a) hereafter, mhGAP-IG]. The mhGAP-IG is part of a larger portfolio of products including training materials and implementation and operations manuals (WHO, 2016a; Mills, 2019).

The mhGAP-IG has become the principal clinical tool being used as part of the scaling up strategy of the mhGAP programme in LMICs, serving as “the standard approach for all countries and health sectors” (Patel et al., 2011.p. 1442).The second most important policy document is the Lancet Commission on Global Mental Health and Sustainable Development [hereafter, the Lancet Commission] (Hermman et al., 2022; Patel et al., 2018). The third policy document in focus here is the WHO’s Depression Strategy (WHO, 2012). These three main documents deserve a careful analytic reading because they establish a foundation for key components of the GMH approach to address depression as a public health crisis worldwide, including in the Global South, along with the dominant global treatment gap discourses. While all three above documents are analyzed in what follows, particular attention is paid to the mhGAP-IG. The WHO describes the mhGAP-IG as “an evidence-based technical tool aimed at supporting non-specialised healthcare providers to redistribute clinical tasks previously reserved for mental health specialists” (WHO, 2017a. p. 75).

The mhGAP-IG is unpacked in greater detail in this analysis given its global significance, evident in the fact that the mhGAP-IG was used in over 100 countries and translated into more than 20 languages(WHO, 2016; Mills, 2023; Keynejad et al., 2018).The global significance of the mhGAP-IG makes it especially important to question or explore the conditions of production of its tools and guidelines, their underlying theories and assumptions about mental health, (i.e., depression) and how the kinds of knowledge that these guidelines create have implications for the governance and experience of mental health in the Global South. Findings are, therefore, interpreted and discussed considering the historical, political, and cultural context, therapeutic, and the personal and social implications of how depression is understood.

5.3. Findings: Emerged Themes and Analysis

The analysis of the selected documents reveals a set of global dominant discourses that are based on implicit problematic assumptions that underlie current global mental health practice and depression research. This analysis proposes that the dominant narrative discourse of GMH displays six major themes that are ideological in nature: 1) The Architecture of Depression: The Coming into Being of as an Illness Like No Other; 2) "The Reach Paradigm": Universalization and the Transfer of Subjectivities; 3) Individualization, Responsibilization and Self-Management; 4) Evidence-Based Treatment, Standardization, and Audit; 5) Routine Depression Screening in GMH: Psychiatric Risk Profiling of Human Suffering; and 6) Dancing with Complexity: The Supply and Demand Dilemma

for Addressing the Depression "treatment gap." These themes serve as powerful currents to perpetuate the dominant norms and restrict the scope of our thoughts, strategies, research, and actions. We closely examined the ideological underpinnings of these themes below.

5.3.1 The Architecture of Depression: The Coming in to Being of an Illness like No Other

The mhGAP-Intervention Guides (mhGAP-IG) (WHO, 2016) and its associated “packages of care” (Patel et al., 2009) are tools designed for non-specialists to detect, diagnose, manage, and educate the public about common mental disorders in LMICs. The dominant discourse in GMH is that in LMICs, the treatment gaps for depression alone ranges from 82 - 98 % (Chisholm et al., 2007; Moitra et al., 2022) and hence there is a need for more clinical service to close the gap. The WHO’s mhGAP (mhGAP-IG) 2.0 (WHO, 2016) defines itself as a key component in closing this gap. It is presented as "evidence-based tools" and guidelines to help detect, diagnose, and manage the most common mental, neurological, and substance use disorders (WHO, 2016, p. 2). Specifically, the documents are developed to aid "non-specialist audiences" (i.e., doctors, nurses, other health workers, without mental health specialists, as well as health planners and managers) (WHO, 2016).

The international guidelines, such as mhGAP-IG, have not only been used as clinical tools, but they have also been used as training courses and research tools in LMICs (WHO, 2016a, 2016). As a result, as advocated by Patel and his collogues WHO’s mhGAP-Intervention Guides have become “the standard approach for all countries and health sectors"(Patel et al., p. 1442). Thus, over the last two decades, not only the construct of depression was viewed as universal and objectively measured, but also the guidelines and drug-based strategies that became universalized, institutionalised, and legitimised on a massive scale: international guidelines for all—"to make mental health for all a reality"(Patel et al., 2011, p. 90). Because of such dominant discourses, the guidelines are increasingly serving as the ultimate source of knowledge and evidence-based reasoning for research agendas, funding, interventions, and scientific curiosities—what Foucault refers to as a "regime of truth” (Foucault, 1973, 1980).

"Truth," Foucault tells us, “Is to be understood as a system of ordered procedures for the production, regulation, distribution, and operation of statements” (Foucault, 1973, p. 56). This constructed ‘truth’ about depression, for example, has been achieved through different apparatuses and statements that have been circulated in publications, international organizations, and lobbying efforts. Because of this circulated "truth," depression has been framed as an "epidemic," which has been established as a

major threat to the planet, prompting every government in LMICs to take action by making anti-depressants more widely available (WHO, 2001a; WHO, 2001b). This is the truth and power of biopolitics. In most LMICs, it is crucial to acknowledge that depression is often not perceived solely as a medical issue or a straightforward illness. Instead, it tends to be situated and comprehended within the broader sociocultural context of these societies. Various cultural norms, social functioning patterns, and the unique cultural contexts in LMICs significantly influence how depression is perceived and managed (Haroz et al., 2017; Lewis-Fernández & Kirmayer, 2019).

Over 30 years of cross-cultural mental health research has shown that what constitutes a symptom of psychological distress or disturbance worthy of concern and clinical health seeking varies across and even within cultural settings (Kirmayer & Pedersen, 2014; Lewis-Fernández & Kirmayer, 2019). Moreover, people in the Global South routinely interpret their psychological and emotional states as reactions to social and economic problems, not as health conditions that can be addressed by medical services (Roberts et al., 2022; Torre, 2022; White & Sashidhran, 2014).Therefore, the GMH's continual promotion of depression as an illness like no other in LMICs can serve as an apparatus for the (re)production of subjectivities(Lewis-Fernández &Kirmayer, 2019). The mhGAP-IG disregards ongoing debate about the cross-cultural validity of psychiatric diagnoses. It suggests a primary reliance on psychotropic medication (Applbaum, 2015) obscures structural determinants of distress and ignores grassroots approaches to healing (Kirmayer & Pedersen, 2014).

It also constructs mental health as primarily a technical problem of service delivery—a problem treatable with care packages (Applbaum, 2015). This discourse, whether intentionally or not, individualizes, pathologizes, and decontextualizes distress. It also emphasizes personal responsibility (Foucault, 2010; Rose, 1999). In the process, such ways of thinking prevent alternative frameworks or broader solutions from emerging, and it also creates conceptual voids that reproduce inequity and oppression, resulting in "epistemic injustice" when it comes to speaking about and coping with depression in the LMIC context (Fricker, 2003).

5.3.2 **"The Reach Paradigm": Universalization and the Transfer of Subjectivities**

The dominant notion that the central challenge of public mental health is to ensure that mental health expertise reaches more people has been dubbed the "reach paradigm" (Knibbe, de Vries, Horstman, p.67). This dominant notion circulated in the GMH discourse has justified prioritization of more clinical services being developed in LMICs to address mental health needs (Eaton, et al., 2011).

The issue here is not with expansion in service provision per say, but in the expansion of services fashioned on assumptions about the biomedical and individual nature of depression that become reinforced when new clinical services are based on the mhGAP. The guidelines' explicit global framing as a global standard (Patel et al., 2011) and role as a foundation for scaling up mental health services for depression[8] make them a significant focal point for research into the types of knowledge, techniques, and practises that construct and perform mental disorders, as if they can be universally addressed by a clinical solution. As such, investigating the biopolitical rationality of the mhGAP guidelines provides insight into the processes through which universality is negotiated, enacted, and contested, as well as the "conceptual shifts and ruptures in the way universality is claimed" within GMH (Bemme & D'Souza, 2014, p. 856).

Universality in GMH is "ambiguous and precarious" and is "contingently and collectively produced" (Timmermans & Berg, 1997, p. 277) as the result of the historically situated, distributed work of a multitude of actors (Ecks, 2021). One of the important historical conditions of possibility for the mhGAP guidelines is the rise of evidence-based medicine (EBM) (Bemme & D'Souza, 2014; Ecks, 2021). The emphasis on GMH interventions for depression being evidence-based has been central to constructing mental health as global (Collins et al., 2011; Mills, 2023). EBM is itself an empirical object that has gained global currency, to bring more certainty to clinical decision-making, made possible through linkages between the historically separate areas of epidemiology and medical research to offer a more systematized, scientific approach to the practise of medicine (Bemme &D'Souza, 2014). However, where evidence that meets the criteria for EBM in GMH does not exist (as is common in LMICs for depression (Baxter et al., 2014; Brhlikova et al., 2011; Ecks, 2021) the lack of evidence discursively became a moral imperative (Kleinman, 2009).

The WHO's strong emphasis on evidence-based guidelines (i.e., mhGAP) raises important questions about what constitutes evidence in GMH (Ingleby, 2014). Historically, systems of standardization are a "significant site of political and ethical work" (Boweker &Star, 1999, p. 147) because every standard "valorizes some point of view and silences another" (Boweker &Star, 1999, p. 156), making them part of "the knowledge-power processes that inscribe and materialize" the world in particular ways (Haraway, 1977, p. 7).

According to Lakoff (2005) such standardization, through the reduction of complexity, specificity, and locality, makes an asset transferable across different contexts—achieving "diagnostic liquidity"(p 68). Guidelines production is thus one of the central practises through which "the apparently universal validity of biomedical knowledge is materially and discursively forged via the standardisation of practise across multiple domains" (Lakoff, 2005, p. 66-7), resulting in the transfer of subjectivities. In this regard, evidence has shown that the wholesale export of psychiatric conceptions of mental illness from HICs to LMICs has changed how distress manifests and introduced barriers to recovery (e.g., expressed emotions in families of individuals with psychosis in Tanzania, Peru, and Sri Lanka) (Watter, 2010; Kitanaka, 2011). By the same token, the WHO's mhGAP Guidelines involve material and institutional discursive practices that aim to contingently produce 'universality' in mental health and the understanding of depression. That is to say that these guidelines are not neutral, value-free documents, nor are they merely passive descriptions. They are also authoritative documents that can do more than describe the territory of depression.

As Bowker and Star (1999, P. 59) note, these documents do not just "sort things out," they also link things together. The argument is that the assumptions that are rooted in the GMH packages of care and WHO strategic guidelines have a unique way of defining what constitutes a mental health problem and what counts as relevant knowledge for intervention that is not applicable in the different context of LMICs (Gómez-Carrill, et al., 2020). Consequently, guidelines and diagnosis manuals have a potential to create a different kind of self and personhood through "looping effects "at the clinical as well as at the population level in LMICs (Hacking, 1999, p. 100). A "looping effect" refers to the tendency for social categories to reshape human experience in a manner that conforms to the category (Hacking, 1999). As Jarvis and Kirmayer state looping effects can occur at many levels, including within the body, between the body and interpersonal interactions, and between individual cognition and the social environment (Jarvis &Kirmayer, 2021). It has been shown that at the social level, diagnostic constructs become figurative as they move out of professional practice into the metaphorical world of popular culture and individual experience (Hacking, 1999; Jarvis & Kirmayer, 2021).

Thus, a diagnostic category like depression can become part of a popular idiom ("being depressed"), which becomes a way to talk about everyday life challenges (Lewis-Fernández & Kirmayer, 2019). There is a wealth of evidence that the clinical use of the category of depression has enabled people to reinterpret suffering in ways that change their experience and expectations for treatment and that influence clinical diagnostic practice in a self-confirming loop (Kitanaka, 2011; Hari, 2018). Such epistemic problems of looping effects should be seriously considered in relation to the aspirations of global mental health in addressing depression in LMICs.

5.3.3 Evidence-based Treatment, Standardization, and Audit

> Depression is a disorder that can be reliably diagnosed and treated in primary care. For common mental disorders such as depression being managed in primary care settings, the key interventions are treated with antidepressant drugs and psychotherapy. Treating depression in primary care is feasible, affordable, and cost-effective (WHO, 2012, p. 7).

While all the documents suggest that individuals, as well as their families, communities, and workplaces, should be encouraged to take on responsibility for addressing depression, the mhGAP guideline reflects a particular interest in governing professional practice with a view to shaping clinicians' treatment decisions in desired (cost-minimizing) directions. This interest is reflected in two discursive strategies visible in that document: (1) arguments that only treatment approaches that are ‘‘evidence-based’’ should be encouraged; and (2) support for measures to standardize and audit treatment choices and practice to ensure that they conform to evidence-based insights. Both discursive strategies work to constrain the discretion that practitioners otherwise might proposed based on their expert and contextual knowledge, training, and experience; in so doing, they exemplify biopolitical technologies of rule that enable ‘‘governing at a distance’’ (Foucault, 2010).

The notion that we should support clinical practices which are supported by the available evidence is, on the face of it, difficult to contest. The discourse of ‘‘evidence-based’’ thus serves as an effective way to impose closure on the lively debates that exist about the risks and benefits of various treatments that are available for depression (WHO, 2016a; 2016). With “evidence-based” recommendations for the treatment of depression teleologically justified, calls for standardization are likewise justified. However, as an extensive literature points out, there are several levels on which such arguments can be challenged.

For starters, there has been substantial concern expressed about the conventional ‘‘hierarchy of evidence’’ within which data collected through randomized clinical trials is understood to constitute the ‘‘gold standard’’ (Fernando, 2014). Critics contend that this conceptualization of evidence creates a bias favoring research that focuses on individual-level variables and treatment approaches. In so doing, it fails to adequately consider the qualitative research findings which identify a variety of socio- economic, and political influences on health and indicate the need for interventions designed to address these contextual features of people's lives (Kirmayer & Pedersen, 2014; Kirmayer & Swartz, 2013). The mhGAP programme's conception of the treatment gap relies largely on burden of disease metrics, and very frequently references them (WHO, 2001a; WHO, 2001b; WHO, 2008, 2013, 2021) as does global mental health literature (Lund et al., 2011, p. 1). This shows Global Burden of Disease calculations as an important rhetorical resource within global mental health (Collins, et al., 2011). The fact is, as scholars have noted, our global data on causes and prevalence of depression in specific settings around the world are far less robust than acknowledged in the promotion of GMH as morally necessary (Baxter et al., 2014; Brhlikova et al., 2011). But numbers are usually political, and they are mobilized in the service of moral objectives. As Starr stated, while "the characterization of people is myriad and subtly varied, statistical systems reduce complexity, incorporating this myriad into a single domain, and very often generating a single number that will appear in headlines, in speeches, and the reports" (Starr, 1987, p. 40).

According to worldwide projections from the WHO, by 2030, the amount of disability and life lost from depression will surpass that from war, accidents, cancer, stroke, and heart disease (WHO, 2021, WHO, 2017b). Such statements serve as a moral imperative to make depression universal and globally visible and in demand of attention. Paradoxically, in this move aimed at increasing recognition and action, the range of realities and contributors to depression are erased. Despite the many contestable features of claims that clinical treatments for depression should be supported because they are evidence-based, this is a concept that is used in the mhGAP Guidelines as if both its meaning and its implications are self-evident. This is not to suggest that such efforts inevitably or absolutely constrain clinical decision-making, rendering it consistent with the goals of those who seek to govern. It is nevertheless important to note how the discourse of "evidence-based" can serve as a strategic resource in efforts to undermine the credibility of a range of interventions beyond the ‘clinical gaze’ (Foucault, 2009/1965). In other words, this poses an ethical risk in the context of LMICs because these documents are intended to serve as a primary guide for training psychiatric

personnel, developing diagnostic and screening tools, and educating the public (WHO, 2016, 2021). In practice, this also means providing explanations that do not fit well with local understandings or that undermine interpretive systems that are associated with coping strategies, healing practices, social support, and integration (Kirmayer & Pedersen, 2014; Ecks, 2021; Burgess & Campbell, 2014).

5.3.4 Individualization, Responsibilization and Self-management

In framing the problem needing to be addressed, documents such as the mhGAP guidelines direct our attention to the individual with depression rather than to the broader socio-political environment—including current public policy choices—that might be understood as contributing to the high rates of depression among members of the public. The Lancet Commission does identify features of the social and policy environment that could be significant in shaping individuals' emotional well-being (Patel et al., 2018). This notes, for example, that unjust social structures (among other factors) contribute to mental health problems (Patel et al., 2018). In its report, the Lancet Commission reframes mental health through the lens of sustainable development and advocates for a dimension-based model mapped along the spectrum of distress - disorder - disability.

Most recently, the New Lancet Commission also called for a united action to address depression (Herrman et al., 2022). In this piece, the Commission calls for a public health perspective on depression that addresses its social structural determinants and the severity, breadth, and durability of its consequences, but the commission "emphasises the importance of detecting and diagnosing depression early, which depends on good access to health care" (Herrman et al., 2022, p. 885). While the Lancet Commission does allude to "public health approaches" as one component of a supportive environment for mental health (Patel et al, 2018), it does not expand on this proposal in any detail. Instead, a conceptualization of mental health as a problem within individuals who can be made more or less effectively aware of risks and options for managing what is ultimately a biologically based condition is repeated. For example, a focus on the individual is visible in the way the Lancet Commission takes up the question of why the "burden of disease" generated by depression persists (Herrman et al., 2022, p. 885). The document notes that "[e]ffective health promotion and prevention services in communities, schools, and workplaces have been studied and promoted, yet the incidence and prevalence of mental disorders continue to increase" (Herrman et al., 2022; WHO, 2016a, WHO, 2016).

As such, the explanatory focus is on knowledge and information gaps that leave individuals unable to identify the presence of depression and/or likely to make ineffective or inappropriate choices regarding treatment (Herrman et al., 2022; Patel., et al 2018). All documents thus construct those who are ill or at risk of becoming ill as subjects who, through their social and healthcare environments, may be more or less enabled to recognise and manage their suffering, while leaving earlier assumptions about the individual biomedical source of that suffering intact. There is a departure from the earlier framing of those in need of global mental health resources as "passive recipients of treatment." But what stands in its stead is an equally limiting construction of subjects in and of global mental health as, to borrow from Foucauldian scholar Nicolas Rose, “enterprising selves" who are incited to live as if making a project of themselves; they are to work on their emotional world” (Rose, 199, P. 157).

In summary, even in its most recent iterations, GMH discourse drives toward a methodological individualism that focuses on individual-level biological causes, attributes, or risk factors that lend themselves as "targets of intervention" for depression. This point of view is associated with the search for behavioural or technological interventions that are unrelated to specific contexts. What emerges is a single story of change, perpetuating universalizing values, beliefs, culture, and practises associated with depression which may or may not connect to actual conditions in which people live and which may be key contributors to their depression.

5.3.5 Routine Depression Screening in GMH: Psychiatric Risk Profiling of Human Suffering?

> Based on experience and the recent recommendations of the US Preventive Services Task Force, we propose the implementation of screening for depression in routine care…for all adult attenders. The use of brief, self-report questionnaires, such as the Patient Health Questionnaire (PHQ-9), takes a few minutes to complete, can be used to generate a diagnostic outcome, and shows sensitivity to treatment response. Routine screening for depression in adult primary care attendees is a vital milestone in the journey towards reducing the very large treatment gaps (Reynolds & Patel, 2017, p. 316).

In light of the economic burden of depression, there has recently been a push for the need for routine depression screening (Reynolds & Patel, 2017; Trautmann, Rehm & Wittchen, 2016). In the US, despite a lack of evidence to support routine depression screening (Cosgrove et al, 2017; Thombs et

al., 2018), it has been recommended by the United States Prevention Services Task Force (USPSTF) for everyone over 13, including for the first-time during pregnancy and the post-partum period (USPSTF, 2016). It is worth noting that the UK and Canada, looking at the same evidence as the US, made the explicit recommendation against screening due to concerns about over-diagnosis, overtreatment, and thus exposing people to the risks of treatment, particularly antidepressants and second-generation antipsychotics, without enough evidence of benefit (Cosgrove & Karter, 2018). While universal depression screening remains controversial in the United States and elsewhere, advocates or leaders of the global mental health framework are ardently advocating for its implementation in LMICs.

Reynolds and Patel (2017), for example, lament in a World Psychiatry article that efforts to train primary care practitioners in Colombia, India, Sudan, and the Philippines to detect mental disorders have failed to increase diagnosis rates. They argue that instituting the practise of screening all primary care attendees in these settings with variations of the Patient Health Questionnaire (PHQ-9; a 9-item screening tool developed by Pfizer) would be "a critical milestone in the journey towards reducing the very large treatment gaps globally and scaling up the robust evidence on cost-effective interventions"(Reynolds & Patel, 2017. P. 316). The argument for increased use of depression screening tools at an international level is typically framed in terms of the social and economic "burden" of depression, but it raises critical concerns about the ethnocentric quality of instruments that are frequently glossed over (Mills, 2014).

In such a way, the token of depression has become the "enoncé " for GMH practises that map, measure, and calculate human suffering (Hacking, 2002, p.91). Once established, this " enoncé" never stops counting or mapping people and their concerns about suffering. It becomes authentic and has the power to make a new category of people or subjects, which Hacking calls "making up of people" psychiatric subjects (Hacking, 2002, p. 99). For Hacking, "making up' is the bringing into being of specific ways of being a person that may not have been possible before. Here, we want to underline that it does not mean that people who experience distress do not exist in LMICs. Instead, such people may not have recognised their distress as illness or "depression" and thus sought psychological or psychiatric help (Osborn et al, 2021; Tekola et al., 2023; Roberts et al., 2022; Torre, 2022).

In the GMH space, treating depression, or more specifically, detecting depression in LMICs, has become a source of contention. On the one hand, studies in LMICs indicate that the number of people affected by depressive illness in primary care settings is increasing (Thornicroft et al., 2017) and that there is a significant treatment gap: approximately 90% of people who are thought to be seeking depression care did not receive any (Chisholm, et al., 2016; Moitra et al., 2022). Other studies show low rates of detection of depression (Reynolds & Patel, 2017; Fekadu et al., 2017; Fekadu et al., 2020). Although the construction of a "treatment gap paradigm" with its rhetorical sense of urgency is a key condition of possibility and a central narrative trope for the development of the mhGAP, to address the depression treatment "gap" in LMICs, these contradictory findings raise several questions such as: is there a gap in access to treatment, or is there a gap between global diagnostic tools and local definitions of depression? Therefore, the supply and demand dilemma logic under the notion of a treatment gap has been a long-standing problem in the GMH space to address depression.

5.3.6 Dancing with Complexity: The Supply and Demand Dilemma for Addressing Depression 'Treatment Gap' in LMICs.

In the GMH discourse, the "treatment gap" is often taken to indicate a shortage of mental health services in LMICs, and most people who are suffering from depression do not get the treatment they deserve (Patel et al., 2018). It has also been justified to focus on increasing more access to mental health services, particularly in settings where resources are most scarce. In other words, there is a problem of supply, supported by evidence of resource deficits for mental healthcare ((Bemme & D'Souza, 2014). This was also the driving force behind the development of international guidelines and circulated to LMICs to bridge the gap. However, there is evidence that suggests an alternative interpretation of rationality's demand-supply logic in the case of depression and other common mental disorders. The World Mental Health Surveys, which were conducted in 24 countries with 63, 678 participants, revealed that the most frequently reported reason for not seeking treatment for mental health problems was a lack of perceived need for treatment (Andrade et al., 2014). This finding supports the assumption that many people who fall into the "treatment gap" do not want treatment for their depression or anxiety symptoms (Roberts et al, 2022; Torre, 2022).

More studies have also shown that "closing the treatment gap" for depression and other common mental disorders in GMH research and practice has become more of a demand issue than a supply issue. A report from the Programme for Improving Mental Healthcare (PRIME), an 8-year initiative to increase the supply of mental health services in five LMICs (Ethiopia, Uganda, India, Nepal, and South Africa), for example, confirmed that increasing the supply of mental health services does not close the treatment gap for depression in the absence of demand (Roberts et al, 2022).In the GMH discourse and literature, limited attention has been focused on explaining the main reasons behind the lack of demand for mental health services for depression. Prominent scholars in the GMH field assert that limited demand for mental health services in LMICs can be attributed to factors like stigma and access barriers, including travel costs (Patel et al., 2011). Importantly, individuals may forgo seeking or disengage from mental health services, believing that their well-being results primarily from social and economic adversities, rather than being treatable medical conditions. For instance, depression may be attributed to poverty, family conflicts, job instability, or lack of employment, with an emphasis on addressing these socio-economic challenges for improved mental well-being (Bracken et al., 2016; Kirmayer & Pedersen, 2014; Roberts et al., 2022; Torre, 2022; Lund et al., 2011). This suggests the significance of addressing psychosocial factors alongside psychiatric interventions for depression.

This argument is consistent with the primary notion of the treatment gap and echoed in the recent Lancet—World Psychiatric Association Commission piece, "Time for United Action on Depression" (Herrman et al., 2022). Stigma and barriers to access care are well documented realities that play a role in limited demand for mental health services, but these factors do not negate the importance of exploring how standardized definitions and treatments of depression fit with local understandings. Several recent qualitative studies, for example, have shown that across multiple low-resource settings in the Global South, people fail to seek mental health services and disengage from services because people interpret their psychological and emotional states as reactions to social and economic problems, not as health conditions that can be addressed by medical services (Tekola et al., 2023; Roberts et al., 2022; Torre, 2022). These studies add to the growing body of evidence that de-contextualized approaches to mental health treatment make little sense for people experiencing psychological distress because of ongoing adversity (Mills, 2014; Burgess et al., 2020). In other words, in addition to a health sector response, we also require a societal response to the causes of common mental disorders like depression that lie beyond the health sector.

In line with this perspective, we wholeheartedly agree with Summerfield, who illustrates how a simple gift of a cow acted as an effective "antidepressant and painkiller" for a farmer in Cambodia experiencing distress due to income insecurity; another intervention doesn't conform to the conventional paradigm (Summerfield, 2013, Par.8). Thus, it raises questions about whether the concept of a "treatment gap" should consistently be interpreted as indicating a substantial unmet need for mental health services, as is often emphasized in Global Mental Health (GMH) initiatives or as a reflection of low demand for biomedical solutions to issues that individuals perceive as rooted in social and economic challenges(Lund et al., 2011; Roberts et al., 2022; Burgess et al., 2020). This further leads to the idea that decontextualized approaches to mental health treatment and care might make a little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty. To address depression, and other common mental disorders, re-conceptualizing the treatment gap is crucial in the Global South, where many forms of adversity people face can and should be addressed directly without a clinical space.

5.4. Discussion

Health policy making in global health is a complex and multifaceted process that is influenced by a multitude of factors, ranging from scientific evidence and economic considerations to political ideologies and social values (Mills, 2014; Summerfield, 2006, 2013; Bracken et al., 2016; Ingleby, 2014; Kirmayer & Pedersen, 2014). In the context of the Global South, where many nations face unique challenges in providing adequate healthcare for their populations, power relations play a crucial role in shaping health policies. These power relations, often driven by historical legacies, economic disparities, and geopolitical dynamics, exert a profound impact on the formulation, implementation, and outcomes of health policies in these regions (Mills, 2014; Kirmayer & Pedersen, 2014). The domain of GMH introduces an additional layer of complexity to this discourse.

In the GMH space, power dynamics manifest in various ways. Firstly, there exists a significant disparity in knowledge and resources between high-income countries (HICs), where much mental health research is conducted, and LMICs, where the burden of mental health conditions is often projected the highest (Herrman, 2022; Chisholm et al., 2016; Collins et al., 2011). However, there has also been a dearth of research in LMICs where interventions chosen for scaling up tend to align with research methodologies favored by evidence-based medicine, which often favor pharmacological and manualized psychological therapies (Ingleby, 2014; Summerfield, 2013; Ecks,

2021). However, it often fails to empower local actors to challenge the motives and values embedded in global mental health projects or to leverage their own community competencies and solutions of psychosocial care and support (Kirmayer & Pedersen, 2014; Kirmayer & Swartz, 2013). Secondly, the role of international organizations and global mental health initiatives, such as the World Health Organization's Mental Health Action Plan (2013-2020), and now extended to 2030 in shaping mental health policies in the Global South is significant (WHO, 2013; Patel, et al., 2018). These organizations possess substantial influence in setting the agenda for mental health care, yet their decisions may not always align with the unique needs and contexts of individual countries and diverse contexts.

In fact, the current approach to scale within GMH is deeply influenced by the perceived success of the global HIV/AIDS response, which frames mental health as a global problem with a universal solution (Mills, 2014). This perspective raises important questions about what exactly is being scaled and what politics of scale are at play (Mills, 2014; Ecks, 2021). GMH often mirrors Western psychiatric models, emphasizing symptom-based management and evidence-based interventions, raising questions about its universal applicability. GMH has attempted to address these critiques through a "staging model of mental disorders," (Patel et al, 2018) but it still predominantly focuses on symptom-based management This narrow view shapes how solutions are identified and developed, emphasizing the scaling up of evidence-based interventions, despite debates about the applicability and validity of evidence-based medicine to mental health treatment globally. In this context, GMH's approach to scaling up reinforces the notion that the global and local are distinct and hierarchical units, with the global taking precedence over the local.

Moreover, GMH's approach is deeply rooted in neoliberal values, prioritizing economic productivity over holistic well-being— where mental health services are evaluated primarily based on their economic efficiency and ability to restore individuals to economic productivity, especially in the context of depression (Chisholm et al., 2016). The overemphasis on economic considerations can detract from the holistic understanding of mental health, which encompasses broader social and structural determinants beyond symptom reduction and economic productivity. Therefore, instead of solely focusing on how to treat individuals, the focus should shift toward how systems can support people in living meaningful and socially inclusive lives. This reframing invites a broader reconceptualization of mental health care, one that recognizes the complex interplay of social and

structural determinants. To achieve this shift, it is crucial to re-evaluate the values promoted by scaling up strategies, acknowledging the power disparities that determine what is considered "global" or "local" and what interventions are scaled and largely promoted.

5.5. Conclusion

A key condition of possibility and a central narrative trope for the development of mhGAP and its products is the construction of a 'treatment gap'. GMH assumes that depression treatment gaps in LMICs are enormous. In the discourse of Global Mental Health, the term "treatment gap" is usually interpreted as an indication that mental health services are not available in LMICs, and people who suffer from mental illnesses such as depression are not getting the care they need. As such, largely addressing depression in health-care settings has been given a priority. Yet, through our critical discourse and document analysis, we have been able to identify a set of key themes that challenges the current practice of depression in GMH in resource- limited settings.

This analysis demonstrated that there are several persistent dominant ideological norms which have a profound influence (consciously and subconsciously) on GMH's programmatic strategies and scope for addressing depression. The prime example of this kind is the GMH leaders' extreme solutions or recommendations like routine depression screening at the primary health care level to detect depression more to close the 'gap while two decades of research evidence still show a low rate of detecting depression (Ecks, 2021; Baxter et al., 2014; Brhlikova, et al, 2011). The Mental Health GAP guidelines represent a key example of a techno-scientific object that contributes to the universality of mental health (Mills, 2023; Mills & Lacroix, 2019). However, the universality achieved through the implementation of the mhGAP Guidelines is always partial and contingent (Bemme, 2019; Bemme & Kirmayer, 2020; Bemme, 2023; Mills, 2023). Moreover, it is pertinent to note that international guidelines are embedded and circulated within the broader global mental health assemblage (crafted using rhetorical global metrics (burden), funding, EBM, etc.).

Thus, the mhGAP mobilises a moral call for action based on a quantified understanding of the scale of the 'problem,' which has been effective over the past two decades for the global visibility of depression. In this sense, the mhGAP-IG appeared as a solution, a way for governments and clinicians in the Global South to reduce the quantified burden of psychiatric illness (i.e., depression).In fact, the mhGAP-IG has since come to be used in the production of metrics, such as

for economic modelling (highlighting the economic burden of depression) and to make a case for the "return on investment" of interventions (Chisholm et al., 2016, p. 415).

In this analysis, we highlighted how international guidelines like mhGAP operate as part of "the knowledge-power processes that inscribe and materialize" (Haraway, 1977, p. 7), i.e., comprehend mental health differently (as an illness, as universal, and as measurable) than in other contexts. It is thus possible to see that the mhGAP-IG functions as a global 'inscription device' that reinforces and reifies specific theories and practices (Latour & Woolgar,1979). As a result, the "ethno-specific narrative field" (Haraway, 1977, p. 4) of mhGAP-IG is portrayed as universal, while the guidelines function as a means of connecting and circulating different ideals of distress in a manner already defined by Euro-American standards (Mills, 2014). In doing so, as we argue, the current dominant paradigm in GMH perpetuates a problematic assumption that human emotions and behaviours can be understood independently of context and that the "symptoms" identified are equally pathological wherever they are encountered (Bracken et al., 2016).

The continual framing of mental health problems and depression in individual terms obscures the role of wider social determinants and encourages the provision of medical interventions rather than public health approaches (Kirmayer & Pedersen, 2014; Gómez-Carrill et al., 2020). More research has also raised this concern that universal criteria fail to reflect locally meaningful constructs, given variation in experiences and idioms of distress between settings (Haroz, et al., 2017; Tekola et al., 2023; Limenih et al., 2024(in press). From the start, the GMH movement evaded the now decades-old question of whether the diagnostics and treatments of Western-rooted and -based defining of depression are applicable in other cultural contexts. Global interventions have, accordingly, become a matter of ''scaling up,'' before and without calling for an investigation into the appropriateness of using standardized diagnostic categories as the basis for measuring need and providing expanded access to care. Therefore, it is critical to consider the epistemological assumptions that underpin with in the mhGAP-imaginary. To move forward with this process effectively, we recommend that we must take the critique of mhGAP-IG seriously, both in terms of its own paradigm and from other epistemological perspectives. Particularly relevant are the multiple perspectives and critiques from "user/survivor/mad" as well as situated, localised, and indigenous epistemologies (Kirmayer & Swartz, 2013; Rose, 2019; Kirmayer, 2012).

We suggest that a radical shift in thinking about programmatic strategies in GMH is possible only when we critically examine the set of norms and assumptions that shape the very foundation of what we produce as 'knowledge' and the programmatic actions that are developed from such knowledge. By inverting dominant discourses, we may also be able to develop alternative approaches and theoretical frameworks. These approaches may help us reorient ourselves fundamentally in a less conventional and more innovative way. We want to stress that our aim in this analysis is not to dismiss the aspirations of GMH, but it is to suggest that there are fundamental problems with the continual framing of mental health under the notion of "treatment gap" that seeks to introduce global standard packages of care without a full understanding of local contexts. We stressed that addressing depression in non-clinical settings is just as significant as addressing it in health-care settings. Since the health-care response has been the dominant discourse in GMH to address depression in LMICs, has been limited the various interventions such as addressing the socio-cultural and economical adversaries people face every day.

While this analysis contributes to the GMH literature about depression research and practice, it does have certain limitations. The analysis, for instance, did not examine in detail how the mhGAP guidelines are applied in practice within a variety of contexts; it did not examine the wider epistemic infrastructure within which the guidelines operate; and, crucially, it failed to consider the impact its diagnoses and recommendations may have on the lives and subjectivities of those affected. Despite these limitations, however, this article argues that the universality of mental disorders is contingent and partial, and the different strategies employed in GMH to address depression can be seen as "contingent universals"(Bemme, 2023) upon which its main thesis is based. Most importantly, although the GMH agenda has placed significant emphasis on expanding services to reach all those who meet diagnostic criteria for common mental disorders, many of them do not consider themselves to need or want such treatment. As a result, we argue, our goal in terms of increasing access to services must be not only that "the human right to care is met but also that people have the ability to improve their lives in ways they consider meaningful" (Roberts et al., 2022, p. 555) (emphasis added).

In summary, providing interventions that address people's mental health needs is central to global mental health, but "treatment" per se does not necessarily meet these needs. We must therefore expand the notion of what constitutes a mental health intervention. The goal of global mental health is not disputable. Increasing access to care and strengthening mental health care in LMICs are important endeavors and timely. However, it is necessary to recognize that long term success in reducing mental distress all around the world will not come from more psychiatric intervention but a genuine reduction of mental ill-health in the LMICs come from large scale socio-political reforms to attack the social determinants of distress which GMH must truly move beyond the treatment gap paradigm.

5.6. References

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Chapter 6

6 Understanding[3] Conceptions of Depression Among Patients and Mental Health Care Providers in Bahirdar City, Northern Ethiopia: A Critical Ethnography Study

6.1. Introduction

Depression is a pressing global public health issue, impacting approximately 350 million individuals worldwide (WHO, 2022; Herrman, 2022). It ranks second in terms of years lost due to disability and significantly contributes to disability-adjusted life years (DALYs) (Vos et al., 2017; Chisholm et al., 2016). Although the prevalence of depression varies globally, prevalence estimates are higher in low- and middle-income countries (LMICs) compared to high-income countries (HICs), especially in regions grappling with complex challenges such as conflict, poverty, and violence (Thornicroft et al., 2017; Charlson et al., 2019). In response to this escalating crisis, Global Mental Health initiatives have collaborated with the World Health Organization (WHO) to develop intervention programs and healthcare packages such as such as the Mental Health Gap Action Programme (mhGAP), tailored to LMICs (WHO, 2008, 2010a, 2016). These initiatives aim to enhance the provision of care and treatment for depressive disorders, along with other mental, neurological, and substance use (MNS) disorders (Collins et al., 2011).

Despite these efforts, practical challenges persist, particularly in culturally diverse settings such as Ethiopia and other LMICs (Kirmayer & Pedersen, 2014). There is also ongoing debate surrounding the applicability and suitability of international guidelines within local norms, practices, and cultural understandings of distress on a global scale (Kirmayer & Pedersen, 2014; Mills, 2015; Mills & Lacroix, 2019; Mills, 2022; Summerfield, 2013). Furthermore, low rates of depression detection or identification and under-recognition in primary healthcare settings remain significant issues in Ethiopia and other LMICs, notably in sub-Saharan Africa (Fekadu et al., 2017, 2022; Mayston et al., 2020; Rathod et al., 2018; Reynolds & Patel, 2017). The way individuals and communities perceive and understand depression is part of the issue (Tekola et al, 2023). Very limited research exists on how Ethiopians express their distress in healthcare and community contexts.

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[3] This chapter is submitted to International Journal of Cross-*cultural Psychiatry (Culture, Medicine and Physiatry) (full information will be available*

Another challenge is that our current global understanding of depression is primarily rooted in Western nosology, which may not apply universally (Haroz et al., 2017; Kirmayer et al., 2017). As a result, existing clinical research and diagnostic practices may fail to capture culturally relevant and salient aspects of depression. Research has shown cultural variations in depression prevalence, symptoms, symptom presentation, and treatment-seeking behavior (Haroz et al., 2017; Ferrari et al., 2013; Kirmayer, 2001, 2005; Kirmayer & Bhugra, 2009; Kirmayer et al., 2017; Kessler & Bromet, 2013; Tekola et al., 2020; Osborn, et al., 2021). Therefore, there is a growing demand in global mental health for expanded research initiatives to understand the significance and relevance of these cultural variations, ultimately enhancing our comprehension of depression and promoting mental health worldwide (Haroz et al., 2017; Kirmayer et al., 2017). Recent calls for a broader, bottom-up approach to depression research emphasize deconstructing the syndrome into its individual symptoms and studying them independently (Kirmayer et al., 2017; Patel et al., 2018) to enhance our understanding about the construct of depression and explore variations in responses to specific situations or challenges commonly associated with depression. We adopted this approach to elicit the construct of depression and its variations.

This study inserts itself within a growing body of studies in Africa that have explored the explanatory models of depression in specific contexts towards informing culturally relevant detection and treatment (Mayston et al., 2020; Tekola et al., 2020; Irankunda & Heatherington, 2017; Osborn, Kleinman & Weisz, 2020). Explanatory models (EMS) encompass “the collective beliefs about illness episodes and their treatment held by individuals involved in the clinical process” (Kleinman, 1980, p. 105). Typically, EMS include four major components: the nature of the illness, its causes, the recommended course of action, and the expected outcome (Kleinman, 1980, 1988). Central to the concept of explanatory models is the recognition that the experience and expression of illness are inseparable from social and cultural contexts (Kleinman, 1980). Broadly, our data analysis approach is influenced by critical and cross-cultural psychiatry scholarship and anthropological perspectives, allowing us to position depression within its ecosocial context (Bhugra & Bhui, 2018; Gómez-Carrill et al., 2020; Kleinman, 1980, 1988; Kirmayer et al., 2017; Kirmayer & Gómez-Carrillo, 2019; Gómez-Carrillo et al., 2023a).

The understanding and response to an illness, such as depression, are shaped by local cultural models and interpretive systems, and any illness carries complex social milieu extending beyond the patient (Kleinman, 1988; Kirmayer, 2019). This approach demands a systematic examination of the social-structural determinants of illness and recognizes illness as a deeply personal experience influenced by socioeconomic, cultural, and political factors (Kirmayer, 2019). We adopt this approach, focusing on Ethiopia, specifically Bahirdar city, a region that has been understudied in global mental health research. This study is part of a larger ethnographic investigation on global mental health, biopolitics, and depression in Ethiopia. Biopolitics explores how various stakeholders, including governments, international organizations, and healthcare providers influence the recognition, diagnosis, and treatment of mental disorders (Foucault, 2010). Often, global health priorities can overshadow local perspectives and socio-cultural contexts, revealing power dynamics that shape mental health policies, practices, and the experiences of individuals with depression in diverse cultural settings. In essence, by neglecting the social contexts that give rise to suffering, mental health services may fail to address what truly matters to many people (Kleinman, 2007).

The first author traveled to Bahirdar city, Northwest Ethiopia, in 2022 and 2023 to explore the conceptualizations and treatment of depression. The article reports on how a sample of Ethiopians, including those with depression and healthcare providers, conceptualize depression within their social environment and how these perceptions influence patients' help-seeking behaviors. Furthermore, we explored whether the global understanding of depression, as defined by DSM-5, aligns with the views and practices related to its expression, causation, and responses as understood among participants in Ethiopia. By providing this comprehensive analysis, we aim to contribute to a more nuanced understanding of depression within the unique cultural context of Ethiopia that can inform culturally appropriate mental health care in the country, ultimately improving the well-being of sufferers.

6.2. Methods

Study Setting: The research took place at two tertiary healthcare facilities situated in Bahir Dar, the capital city of the Amhara regional state, Northwestern Ethiopia. The city has a population of approximately 2 million people. Data collection was specifically carried out by the first author at two hospitals within Bahir Dar: Felege Hiwot Referral Hospital and TibebeGhion Specialized Hospital, both of which having had played pivotal roles in global mental health initiatives, including the

implementation of the Mental Health Gap Action Programme (MGAP) since 2008. The study benefited from the first author's extensive networks derived from 15+ years of work experience as a university lecturer and public health and mental researcher in the research setting. These well-established connections, combined with the first author's Ethiopian nationality, deep familiarity with the region, and fluency in the local language (Amharic), facilitated trust and rapport with participants. Moreover, these qualities enabled her to discern sociocultural references and nuances in participants' responses effectively. It is also crucial to note the challenging context in which this research was conducted. The Amhara region has been significantly affected by an ongoing conflict since November 2020. Initially, this conflict involved the federal government and the Tigray region, and it has subsequently evolved into a conflict between the federal government and the Amhara region. As we write, the Amhara regional state is under a state of emergency, with significant social upheaval that has likely had repercussions on the mental well-being of its residents.

Research Design: The study employed an exploratory qualitative research design using an ethnographic inquiry approach to explore the conception of depression among patients diagnosed with depression and health care providers. The first author conducted semi-structured interviews with individuals diagnosed with depression and mental health professionals within the hospitals in focus. Utilizing ethnographic methods including conversation and in-depth interviews with people with mental illness (e.g., diagnosed with depression), and health professionals within Bahirdar City, the study aimed to discover the particularities of the conception and responses to depression as embedded within the experience of living in a particular cultural/contextual setting. By doing this comprehensive exploration, we aimed to contribute to a more nuanced understanding of depression within the unique cultural context of Ethiopia that can inform culturally appropriate mental health care in the country, ultimately improving the well-being of sufferers.

Participant Recruitment, sampling, and Description: Thirty-five in-depth interviews were conducted, including 20 with individuals diagnosed with major depressive disorder (16 females, 4 males) and 15 with mental health care professionals (9 males, 6 females). Patients were purposefully selected from Bahirdar city and its surrounding areas, primarily from Felegehiwot Referral Hospital and TibebeGhion Specialized Teaching Hospitals. Patients were recruited based on self-reported depression and were asked about their illness, their perceptions about depression, perceived causes,

and their care pathways. The fieldwork occurred in two phases: one from June to November 2022, and the second from June to July 2023. Conflict in the region informed the researcher's decision to complete data collection in two short trips, rather than during one longer stay. The mental health care professionals interviewed included psychiatrists, integrated community mental health professionals, residents, and other mental health experts who were working at these two hospitals.

6.2.1 Data Collection Procedure and Methods

Information was gathered via various ethnographic methods: while in-depth interviews and document analysis form the core of data collected, the researcher also made field notes based on informal conversations and observations in the hospital settings. All in-depth interviews were conducted in Amharic, the official language of Ethiopia. The interviews ranged in duration from 40 to 70 minutes and involved the use of modified open-ended interview guide questions developed by Arthur Kleinman (Kleinman, 1988) illness narratives, covering symptoms, causes, effects, treatment, and health-seeking behaviors. These questions served as a point of departure for subsequent analysis.

6.2.2 Data Analysis Procedure and Methods

In this ethnographic study, data collection and analysis occurred simultaneously (Murchison, 2010; O'Reilly, 2012). Initially, we conducted open coding to identify major words, phrases, and themes. Then, we categorized interviews into conceptual domains (O'Reilly, 2012). The thematic analytic process involved three fundamental stages. Firstly, there was data preparation: In this initial phase, the raw data were gathered, organized, and prepared for analysis. Recordings were transcribed verbatim in Amharic and translated back English by professional translator into English. Quality was ensured by comparing transcripts with audiotapes. Analysis was led and primarily conducted by the first author, who has bilingual proficiency in English and Amharic (native). In this initial stage, she reviewed and revisited the transcripts, generating preliminary codes using Open Code.

In the second stage, she familiarized herself with the data by both listening to the audio recordings and re-reading the transcripts. This involved pattern recognition and coding segments of data and grouping them into meaningful categories. During this phase, analytical ideas that emerged during data familiarization informed the review of the preliminary codes. This iterative process involved refining the codes, selecting those most pertinent to our research questions, and making sense of the data based on patients' explanatory models and in dialogue with the rest of the author team. The third stage was theme development and an in-depth analysis to ensure that the combined codes

harmonized well with the collected data and remained aligned with the study's objectives. Special attention was given to local (Amharic language) terms used to describe conception, symptoms, perceived causation, and explanatory models. When necessary, we have included Amharic words and their English translations into our findings. This comprehensive approach allowed us to explore the nuances of our research questions thoroughly.

Ethical Considerations: The study was approved by the Western University Health Sciences Research Ethics Board (HSREB) (**Ref**:2023-122473-79368) and Amhara Public Health Regional Institute Ethics Board (EPHE) at Bahirdar city (**IRB ref**: NoH/R/T/T/D/07/53). All interviews were conducted after obtaining written informed consent from participants. No identifiers were used during the interviews while transcribing to maintain the privacy of the participants. Participation in the study was voluntary, and participants knew they could decide at any point to opt out. The participants provided both verbal and written informed consent during the interviews.

6.3. Results

The findings are presented in seven major themes: (1) conceptualization of depression and mental illness, (2) cultural conceptualizations of DSM-5 diagnostic symptoms for depression, (3) causes, (4) somatization and social meaning of depression, (5) need for change in social and economic circumstances, and (6) “impaired life" or "stuck in life."

6.3.1 Participant Profile

We conducted 35 in-depth interviews, involving 20 patients with depression (16 females, 4 males, from diverse backgrounds) and 15 mental health professionals (9 males, 6 females, with varied experience). Patients had been diagnosed with depression for varying durations (3 months to 8 years), with most being married (98%) and including farmers, teachers, pensioners, and university students. Most patients were farmers, adhering to the Orthodox Tewahido faith, with ages ranging from 22 to 60 years. The group of healthcare professionals included psychiatrists, residents, psychologists, community mental health professionals, and other mental health experts, with experience levels ranging from 4 to 15 years.

6.3.2 Conceptualization of Depression and Mental Illness

In the initial research stage, we explored how patients conceived of depression in their local context. Patients shared a common view in their narratives, recounting their encounters with depressive symptoms and attributing their mental health challenges to a complex interplay of spiritual, psycho-cultural, and socio-economic factors. Health care practitioners (HCPs) identified "dysfunctionality" as a key feature of depression, affecting patients' work, leisure activities, and social relationships, which is closer to the definition of DSM-5 (APA, 2013). Most participants diagnosed with depression at both hospitals perceived their condition as an illness. For example, they consistently referred to their condition as "distress" (**ጭንቀት ነው**) and "distress of the mind" (***የአንጎል ጭንቀት ነው; የአእምሮ ጭንቀት***; ye’ā nigoli ch’inik’eti new; ye’ā ’imiro ch’inik’et)”. All patients while describing their symptoms of depression they mentioned physical discomforts such as shortness of breath, muscle or bone pain, chest pain, headaches, and tightness.

6.3.3 Cultural Conceptualizations of DSM-5 Diagnostic Symptoms for Depression

While there is no direct Amharic equivalent for the clinical term "depression," healthcare providers have identified the Amharic terms ***"ድብርት"*** (deberete) and "***ድባቴ"*** (Debatee’) as the closest descriptions to "mood swing" and "clinical depression," respectively, in accordance with the DSM-5 definition of depression syndrome. However, it is important to note that these two terms differ in their conceptual depth. Mental health professionals exclusively use the term "**ድባቴ**" (Debatee’) for clinical depression. However, HCPs also reported that “the community does not use this term "**ድባቴ**" (‘Debatee’), especially when referring to distress, and it is not exclusively constituting what clinical depression is (HCP 007). Nevertheless, HCPs frequently used this term for the lack of a better term to describe depression. One healthcare provider explained:

> "**ድባቴ**" (Debatee’) does not precisely capture clinical depression as defined in the DSM-5, and the more commonly used term "**ድብርት**" (deberete) is used by our society to describe general mood swings rather than clinical depression (HCP 009)

Reflecting on the experiences of healthcare providers mentioned above, individuals who identified with depression more frequently used the term "**ድብርት**" (deberet) or almost exclusively used it, in contrast to **ድባቴ** (Debate). However, healthcare providers often understood "**ድብርት**" (deberet) as referring to mood swings, which they found insufficient

to fully capture the complexity of depression or mood disorders. Consequently, for healthcare professionals, a depressive illness was more closely associated with the Ethiopian concept of "**ድባቴ**" (Debatee), a term encompassing "feelings of sorrow and hopelessness" (HCP 009). HCPs reported that individuals with **"ድባቴ"** (Debatee) are easily identifiable by their outward appearance—often appearing downcast and sad—making them more unlikely to openly discuss their issues. They might express sentiments like "**ዝምብሎይደክመኛል"** (I am tired, but I don't know why). People experiencing "**ድባቴ**" (Debatee) also encounter somatic problems, such as general body weakness (**"ድካም")** and physical discomforts like headaches, muscle aches, and appetite loss.

Furthermore, patients may exhibit depression-related symptoms like low energy and difficulty concentrating. These symptoms fall into categories with internal, external, and sometimes supernatural causes (See, Appendix A**).** External environmental factors, such as romantic breakups, marital issues, bereavement, poverty, financial struggles, and unemployment, can contribute to **"ድባቴ"** (Debatee). These external factors cause emotional distress and may contribute to the development of this condition. Societal factors like isolation, domestic violence, family conflicts could also intensify the symptoms of **"ድባቴ"** (Debatee).

6.3.4 Symptom Categories and Symptom Presentation

When asked about their hospital visits and the symptoms they experienced, patients cited a range of somatic symptoms (such as tiredness, fatigue, and headaches), psychological symptoms (like diminished interest in usual tasks), and cognitive/affective indicators. The prevailing symptoms reported by participants dealing with depression encompassed sleep issues (such as trouble falling asleep, nocturnal awakenings, difficulty resuming sleep, and daytime sleepiness), fatigue, emotional distress, aversion to noise (disliking noise**)**, an inclination to shout or hide or disappear, and a desire to leave the house and run. **Table 1** displays the most common symptoms reported by individuals with depression, providing the corresponding local (Amharic) terms/concepts and indicating whether these symptoms align with the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) and the International Classification of Diseases (ICD-11) (WHO, 2022)**.**

When we compare the responses from our in-depth- interviews with patients to DSM-5 and ICD-11 symptom categories, we identified various symptoms of depression that are frequently stated and organized into three broad categories: **ብዙማሰብ** (excessive thoughts), ***ሀይለኛ የራስምታት*** (severe headache), and **ድካም/ዐቅምማጣት** (general body weakness and somatic concerns).

-***ብዙማሰብ*** (excessive thoughts/thinking too much) encapsulates profound cognitive disturbances, yielding a variety of functional impediments. This category encompasses feelings of ***ሀዘን*** (sadness), ***አለመደሰት*** (absence of joy/ being without happiness), ***እንቅልፍማጣት*** (sleep disruptions/lack of sleep and concentration difficulties). It emerged that ***ብዙማሰብ*** was the closest idiom to psychological stress.

-***ድካም ድካም ይለኛል*** (yesewunet medekem/akim matat) refers to a state or a feeling of generalized bodily weakness (lack of energy) characterized by a state without apparent physical causes, accompanied by somatic concerns, including trouble concentrating and loss of appetite. Feeling tired or having little energy is ***"ድካም ድካም ይለኛል"***, which was often attributed or tied to external causes such as experiencing sudden and unexpected or unforeseen news such as death of a loved ones.

-***ጫጫታአልወድም*** (the aversion to noise or Disliking noise), refers to hating or being very sensitive to 'noises' emanating from sources like people talking, conversation or play, or any noise around their presence, and was a shared sentiment among both female and male patients, although it was mentioned mainly by female participants. One female participant said:

> My mind did not like it when people make noises ... noises even when my children play outside, that made me very angry. I felt it. Eh, I even did not like to enter any room which had noises". It irritates me a lot. (P004).

Another female pateint who mentioned disliking noise often talked about being distressed and their head/mind getting disturbed and becoming angry when hearing noise:

> When the dog barks or children are playing outside, it makes me very angry and irritated, and I get a bad headache. I just want to disappear and become a different person (***ይሰዉረኛል***).

Hence, sensitivity to noise was reported as something not good for one's peace of mind and emotional state. Interestingly, the impulse to shout and disappear predominantly emerged among female participants. Strikingly, all female participants who mentioned disliking noises or were very sensitive to noises also reported they had suicidal thoughts and behaviors, including contemplation of stepping in front of moving cars or attempting suicide through ingestion of toxic substances like rat poison (***የይጥመርዝ***) to die.

-እንቅልፍ አልተኛም: sleeping problems, both lack of sleep and excessive sleep, were identified as symptoms of depression. Patients used the idiom, ***'እንቅልፍ አልተኛም***, to refer to moving around in bed and not being able to sleep. For help, traditional sleeping aids (e.g., prayers, drinking herbal sleeping tea) were identified. Most of them also mentioned having sleeping problems, such as difficulty falling asleep and awakening at night, and being trapped or imprisoned in a cycle of sleeplessness. One male participant shared his experience:

> I spent sleepless nights in a vicious cycle, falling asleep in the evening only to wake up and not sleep again. My performance at work suffered, and I lost my sense of self. I used to enjoy teaching and interacting with my collogues, but suddenly, I didn't know who I was or what I wanted. My performance deteriorated. I felt completely lost, went down mentally, and even contemplated suicide.

As such, we observed that this spiraling sleeplessness took its toll, leading to feelings of despair, self-doubt, and even contemplation of suicide.

-ጭምት (Chimet) refers to a well-mannered person. In this study, we found that the act of withdrawing from daily life due to possible depression symptoms and experiencing extreme low moods is mistakenly referred to as ጭምት. The profound silence displayed by someone affected by possible depression is often perceived as a display of good conduct, referred to as 'የማምይክለፈለፍ' (Yemyklefelef) or 'ዝምተኛ' in the community, which may lead to the suffering of a person going unnoticed. Healthcare providers noted that depression symptoms were frequently misinterpreted or mislabelled as ዝምተኛ because people who are seriously depressed do not typically exhibit erratic or 'strange behavior.' In the community, their withdrawal might be considered 'normal behavior.' One healthcare provider commented:

> I had so many cases. Depression symptoms were misinterpreted because seriously depressed individuals often don't exhibit erratic or strange behavior, making it hard to notice if they were depressed or not (HCP 009).

Overall, while many core symptoms of depression align with the current diagnostic criteria (DSM-5) or show substantial overlap, four frequently mentioned symptoms by our patient participants do not

conform to these criteria. Symptoms mentioned or presented by patients while they describe their health condition, including disliking noise, feeling dizzy, tearfulness, severe headaches, and an urge to flee and disappear, did not conform to these criteria (see*, Table 1 below has details of the symptom categories*

Table 2: Most Common Symptoms Repeatedly Reported by Patients Diagnosed with Depression

No	Symptom Dimensions	Spontaneously Reported Symptoms	Local (Amharic) words used	Included in DSM-5/ICD-11 Criteria?
1	Somatic	Problems related to sleep (difficulty falling asleep, awakened at night, difficulty going back to sleep, sleepy in day)	እንቅልፍ አልተኛም (inik’ilifi ālitenyami); ስተኛ እንደ ተጠራ ሰው አባኖ ያስነሳኝ ነበር (sitenya inide tet’era sewi ābano yasinesanyi neberi); የተወሰነ እተኛና ቶሎ እነቃለሁ (yetewesene itenyana tolo inek’alehu); አንዴ ከነቃሁ ደግሞ በጣም ይቆያል (ānidē kenek’ahu degimo bet’ami yik’oyali); ቀን እንቅልፍ እንቅልፍ ይለኛል (k’eni inik’ilifi inik’ilifi yilenyali)	Yes
		Tiredness	ዝምብሎ ድካም ድካም ይለኛል; ድካም ድካም ይለኛል (dikami dikami yilenyali); ድካም/ዐቅምማጣት(akim matate)	Yes
		Feeling dizzy	የዞርብኝ ነበር(Yezorebegn neber); ያዞረኝ ነበር (yazorenyi neberi)	No
		Headache	ሀይለኛ የራስምታት(haylegna yerase mitat); ያመኝ ነበር ጭንቅላቴን (yamenyi neberi ch’inik’ilatēni); የዕራስ ምታት (ye’irasi mitat)	No

		Hard to breath, unable to breath or chocking /feeling of heart attack, short of breath.	መተንፈስ ያቅተኛል(Metenfese Yaketeganle); ልቤቀጥ ይላል(lebe kete Yelake)	No
2	Emotional	Being distressed	ይጨንቀኛል (yich'enik'enyali); ያጨናንቀኛል (yach'enanik'enyali); ጭንቅ ይለኛል (ch'inik'i yilenyali)	Yes
		Loss (complete loss) of interest in work; loss of initiative to work.	ስራ መስራት ጭራሽ አልፈልገውም ነበር (sira mesirati ch'irashi ālifeligewimi neberi)	Yes
		Disliking Noise	ጫጫታ ጫጫታአልወድም ይሰዉረኛል (ch'ach'ata āyiwedilinyimi)	No
		An urge to shout and disappear (run out of the house); an urge to shout; an urge to disappear / to get out of the house and run.	ጮኽሽ ጥፊ ጥፊ ይለኝ ነበር (ch'oẖishi t'ifī t'ifī yilenyi neberi); ጩሂ ጪሂ የሚለኝ (ch'uhī ch'īhī yemīlenyi); ጥፊ ጥፊ ይለኝ ነበር (t'ifī t'ifī yilenyi neberi); ብረሪ ብረሪ፣ ሂጂ ሂጂ ይለኛል (birerī birerī፣ hījī hījī yilenyali)	No
3	Cognitive/Affe ctive	Suicidal thoughts and attempts; Feelings of worthlessness	ጣናውስጥ ዘለሽ ግቢ ይለኛል (Tanwsut zelesh gibi gibi yelegnal) መኪና ውስጥ ግቢ ግቢ ይለኝ ነበር (mekīna wisit'i gibī gibī yilenyi neberi); እራሴን አጥፋ አጥፋ የሚል ውስጤ ላይ ስሜት ነበረው (irasēni āt'ifa āt'ifa yemīli wisit'ē layi simēti neberewi);	Yes

		Being tearful / wanting to cry all the time.	በቃ አለቅሳለሁ (bek'a ālek'isalehu); አልቅሽ አልቅሽ ይለኛል (ālik'ishi ālik'ishi yilenyali)	Yes (but not emphasized)

6.3.5 Somatization and Social Meaning of Depression

Patients commonly reported somatic symptoms or physical discomfort among their symptoms such as severe headaches (***ሀይለኛ የራስምታት***), body weakness (***ድካም ድካም ይለኛል***), fever, shortness of breath, muscle or bone pain, chest pain, and other body pains (***See, Table 1 for details***). Symptoms of somatization have been described as functional, biomedically unexplained, somatic symptoms, somatic preoccupation, or worry about illness, with undue emphasis on the somatic aspects of psychiatric disorders (Kirmayer, 2001). One female participant expressed her concern:

> I have this constant stomach-ache that feels like something is attacking me from within, causing intense pain. …My legs also ache terribly and burning a lot.

Another participant described her experience as follows:

> I've been suffering from this persistent headache for quite some time, but it worsened significantly last year. I tried using holy water (**ጸበል**) (tsebel), but it didn't bring me relief. The pain began when my husband started drinking and subjected me to repeated verbal and physical abuse. I couldn't endure it any longer, and that's when it got worse." (P008 35-year-old woman).

However, when asked or probed into the underlying causes of her physical pain, the participant shared a deeper emotional struggle:

> I worried every day. My husband left me [died] alone, leaving me with four children. My family had pursued me to marry my current husband because I have a lot of farming so that somebody must take care of it. I was not ready to re-married and having another child. … I used to have it all and enjoyed a vibrant social life, actively participating in my community. But now, I do not want to … I pray to God to rescue me from this misery (P0012 a 40-year-old woman).

Patients initially presented somatic symptoms. Upon probing, their narratives about their illnesses revealed statements closely linked to their daily lives and experiences. These physical pains, confined within their bodies, acted as reflections of the events and constraints within the larger social context to which these patients belonged. These physical complaints were rooted in underlying conditions such as family conflicts, marital difficulties, domestic violence, loss, and economic hardships and so on. The

physical distress reflected how social circumstances affected their well-being, highlighting the connection between physical symptoms, moral sentiments, and unexpressed emotions or suffering.

6.3.6 Causes

When asked about the root causes of depression, participants identified seven categories: psychocultural, religious/spiritual, social, familial challenges, economic hardships, behavioral disturbances, substance abuse, and unknown causes. Patients primarily attributed depression to psychosocial and spiritual factors, with family issues such as conflicts between spouses, relationships with in-laws, and incidents of domestic violence, along with financial struggles, being the most frequently mentioned triggers. They deeply embedded spiritual beliefs into their accounts, citing concepts like spirit possession (‘ጸላይ’), the evil eye (ቡዳ), and personal religious struggles as potential causes of their condition. Seeking solace, they initially turned to Holy Water (ጸበል), prayer, and traditional healing services. In this way, spiritual dimensions framed their understanding of their condition, although they also identified non-spiritual factors like difficult life circumstances—such as financial hardships, unemployment, family conflicts, domestic violence, loss of loved ones, and unexpected property loss—as key contributors to their mental health struggles (Annex A) offers the frequent and detailed causes reported by patients, along with the corresponding Amharic language terms/concepts).

All participants regarded their health condition as a social issue rather than merely an illness or spirit inflicted condition. Economic and familial challenges featured in participants’ accounts. For instance, one participant stated how raising children alone and dealing with economic hardships affected her mental health:

> "Raising children on your own, living by yourself can bring about hopelessness. He [her husband] was... after we lost him, I didn't even find anyone to manage my land during the harvesting season. When I rented the land, they didn't use it properly. That makes me so angry." (P004; 32-year-old female participant)

Many female patients attributed their distress to family-related problems, particularly involving control and violence from husbands and family members. For instance, one married woman linked her illness to her husband's control over their shared assets, including livestock and grains:

> He [her husband] often makes me angry, controlled all my possessions, and I felt like a prisoner in my own home. I didn't have a say on my own property. I thought it was better to die than to live like this, so I tried to end my life. (P006 37-year-old female participant)

Another female participant, a widowed woman, reflecting on the onset of her illness, attributed it to her husband's sudden death and her sons' insistence on selling their family home to claim their father's share. She recounted,

> I worked as a textile worker, but after my husband's sudden death, my sons forced me to sell our house. One of them treated me terribly, and it felt like he had become a devil (**ሰይጣንሆነ**). I questioned whether he was even my son. I sold the house, and my life took a sharp decline—a downward spiral. I was filled with anger and sadness, lost control over my home and finances, and had to retire early because I became ill (P12, 50-year-old female participant).

Some patients described initially grappling with uncertainty about the origins of their health conditions. For example, one participant struggled with poor sleep and low energy, which affected their academic performance. She recalled:

> At first, I was confused by my poor sleep and low energy affecting my academics. Later, I faced suicidal thoughts and was hospitalized. There, I was diagnosed with depression, finally explaining my earlier symptoms. That's when I realized I have depression (P008, 22-year-old female university student).

Patients who suggested social, economic, or familial explanations were explicit that, the problems of life they faced could lead to distress, emphasizing the complex interplay between cultural beliefs and difficult life circumstances in Ethiopian perceptions of depression. For instance, a female patient participant stated:

> "Having this unpleasant talk every single day ጭቅጭቅ (chekechek) and his abuse [her husband] rob my peace of mind and makes me ill." (P004).

Substance abuse, particularly alcohol misuse, was reported as a contributing factor to depression among two male patients out of 4 while it was not the reported as the cause for any of female participants. For instance, a male high school teacher disclosed that his depression was rooted in his addiction to khat chewing(ጫትመቃም) (Khat is a local plant based stimulant drug) and alcohol consumption. This was further exacerbated by financial strain when his siblings refused to support his business venture. He shared:

> My illness began when my family didn't support me to run a business. I asked my brother to lend me money, but they think I am useless since I often had chewing chat(ጫትመቃም). Because of that I lost the opportunity. I felt like I have no one. That makes me angry and led me to this illness. It's frustrating when your own family lacks trust and support [P004, 29 -old male participant]

Many male participants attributed their illness to feelings of failure despite their hard work, the inability to provide for their families, and unfavorable comparisons with others they believed were leading better lives:

> I'm a father with three children, and we make a family of five. Despite my hard work, I've struggled to succeed. I've tried various ways to improve my life and support my family, but I keep facing one obstacle after another(*የችግርጋጋታ)(*Yechegergagata). I wonder why my life isn't like others', how some people seem to live well without working hard. This situation makes me both angry and sad..." (P004).

Similarly, several female patients also attributed their distress to the pressure of providing for their families and living in extreme poverty. The most frequently discussed manifestation of poverty was its impact on their children, including concerns about fulfilling their basic needs for food and education and worrying about their future. One female and widowed participant stated:

> I find myself caught in the act of constant worry and sleepless nights about my children's fate and their future. I have two children. I'm a single mother since their father passed away two years ago. My days often feel like a relentless battle to ensure that there's enough food on our table. Most of

> all, I worry about what could happen if something were to happen to me, as they don't have anyone else to rely on. This constant struggle weighs heavily on my heart, casting a shadow of sadness — ልቤን ጥላሸት ያለብሰዋል (P005-28-year-old woman participant).

6.3.7 The Need for Change in Social and Economic Circumstances

Some patients may avoid seeking mental health services or disengage from them due to the belief that their psychological and emotional states are reactions to social and economic problems rather than health conditions that can be addressed by medical services. As noted earlier with reference to causes, poverty, family conflicts, marriage issues, and job instability or lack of stable employment were cited as contributors to depression, with participants expressing the belief that their circumstances needed to change for their mental well-being to improve. Participants often reported believing that a transformation in their circumstances was necessary for their mental well-being to improve. One participant briefly summarized the struggles of a financially challenged individual:

> "What else can a poor man have besides tension [stress]? ... I am a daily laborer. I am out of work right now. Money is my primary concern to lead my family considering the cost of living and inflation in this country. We have no money in our home. If I had money, all my life worries would end. You know um, '[The doctor] can't provide bread to your home. When your hunger is over, your mind will return to normal" (P006).

Similarly, depression is often viewed because of "overthinking" (ብዙማሰብ) triggered by employment instability and other socioeconomic challenges. But medication, according to a participant, may not break this cycle of overthinking. A male participant emphasized:

> The medicine cannot do anything to me to have fewer thoughts; I will only have fewer thoughts when I can support my children and my family (P0012 37-year-old male participant)

Most HCPs were also critical of the services they were providing, stating, "our services are exclusively pharmacological, even though psychological, and social factors are the primary causes of our patients' issues."(HCP 12). In Ethiopia, mental health care services

at the tertiary level primarily focus on pharmacological treatments. This lack of psychosocial services was identified by most mental health providers interviewed as a major obstacle to effectively assisting patients with depression.

6.3.8 "Stuck in life" or Impaired life."

Central to the study's findings is the emergence of the concept of "impaired life." "Impaired life" was a recurring phrase used by both professionals and patients in their comprehending and dealing with depression. Both professionals and patients described depressive episodes as interruptions or stagnations in life, with relationships and life circumstances being significantly impacted. In the words of a psychiatrist, a 30-year-old female, depression resulted in an "impaired life" **የተጎሳቆለ ህይወት** (Yetegosakole Hiowt)" (HCP 001). For Alamirew, a 37-year-old male senior psychiatric professional, depression involved "stop feeling," a feeling of emptiness, and a pessimistic view of reality: "Depression is like: you are there, in your corner, you don't feel anything, you can't feel anything." (HCP 005).

Patients also frequently described their experiences and depressive episodes as feeling "stuck in life"(P002) or trapped in crucial life aspects, leading to a cycle of negative thoughts and emotions. This feeling of being "stuck in life" often fueled a sense of despair and hopelessness. It reinforced the belief that individuals were disconnected from life's possibilities and joys. Take, for instance, Yenenesh, a 50-year-old woman who shared her heart-wrenching experience of losing her son in a recent civil conflict (Ethio-Tigriyan). This event profoundly changed her self-perception and outlook on life:

> He [her son] accompanied me to the local market '**ሰኞ ገበያ**' (segnogebeya). It was on Saturday. Suddenly, armed forces caused chaos, and as we tried to escape, I was attacked, fell to the ground with my son. Bullets flew, but God protected me; the bullet grazed me, but he lost his life. I wish I could die that day. And from then on, I felt that I was like this: I am like a tree. Stuck! I'm not the same Yenenesh I used to be I used to be an active, happy and inviting my neighbors for holiday celebrations. Now, I don't want to go on living. I am half living—'half dead'.

This sense of being "trapped in life" serves as a reminder of how individuals may undergo profound emotional and psychological distress when confronted with existential frustration. Such circumstances can lead to a profound detachment from life's intrinsic meaning and purpose. As one of male patient participants shared and recalled:

> "I had it all once—a flourishing career as a banker, a loving wife, and a precious son. But destiny took a tragic turn, and I found myself losing everything overnight. My wife vanished in secret, taking our son to Dubai due to her family's intervention, as they were incredibly rich. Despite my relentless efforts to locate them, including a journey to Dubai, my search was in vain. Upon my return to Ethiopia, I faced the loss of my job as well. It was as though I had surrendered control over my life. I felt utterly useless. Whenever I attempted to articulate this emotion, it was akin to being trapped in an impenetrable darkness, devoid of any light—***ድቅድቅ, ያለ ጨለማ ዉሰጥ ምንም ብርሃን የሌለበት ቦታ***. I felt stuck." (P009, 34-year-old male participant)

Such descriptions captured well what many participants noted: the ways in which depression could create a feeling of being trapped in life's challenges, leading to existential questioning and a loss of purpose. The concept of "existential frustration," as mentioned by patients, underscores the profound existential dimension of depression, where individuals wrestle with life's meaning and purpose. In this study, the participant's metaphor of "being trapped in an impenetrable darkness" illustrates depression's overwhelming nature. This darkness encompasses the emotional and psychological turmoil of depressive episodes, leaving individuals feeling adrift and devoid of hope. Despite differences in expression, both mental health practitioners and patients portrayed depressive episodes as periods of disruption or stagnation in life's progression. The process of care giving, on the other hand, could serve as a pathway to renewed engagement with life.

Overall, the experience of depression was described as an interruption or stagnation in life, affecting behaviors, personal projects, and family relationships. Participants often attributed their psychological and emotional states to social and economic problems rather than considering them as health conditions that could be addressed by medical

services. They believed that resolving their socioeconomic hardships would alleviate their depressive symptoms.

6.4. Discussion

Drawing on qualitative data, this research explored the perceptions and experiences of individuals diagnosed with depression and health care providers. It explored how patients perceived and lived with depression, as defined in the DSM-V (APA, 2013), and how these personal perspectives may have shaped their help seeking pathways. This study makes a novel contribution to extant literature by including insights from mental health care providers, adding a valuable dimension to the field which has traditionally centered on the accounts of patients. In this study, patients consistently connected the origins of their health condition (i.e., depression), to a multifaceted interplay of spiritual, psycho-cultural, and socio-economic factors. Spiritual beliefs, such as the notion of spirit possession (ጸላይ tselay) and the negative influence of the evil eye (ቡዳ buda), featured prominently in their narratives. Consequently, seeking solace in practices like using holy water (ጸበል' tsebel), prayer, and various traditional rituals emerged as their primary avenue for seeking care.

Our research revealed that challenging life circumstances were often seen as the primary cause of depression. This finding aligns with previous research in sub-Saharan Africa (e.g., Tekola et al., 2020, 2021; Osbon et al., 2021), confirming that socio-economic, cultural, familial, and spiritual factors, including relationship challenges and extreme poverty, were commonly identified as the main causes of depression. Our findings suggest that while many core symptoms of depression align with the current diagnostic criteria (DSM-5) or show substantial overlap, five frequently reported symptoms by our participants do not conform to these criteria. Several symptoms mentioned by our participants, including disliking noise, feeling dizzy, tearfulness, severe headaches, and an urge to flee and disappear, did not conform to these criteria. This highlights the need for culturally relevant assessment tools and a more comprehensive clinical understanding of depression within specific cultural contexts.

Furthermore, our research raised questions about the applicability of standard Western diagnostic criteria, such as the DSM-5, in non-Western cultural settings. Similarly, recent primary studies in sub-Saharan regions (e.g., Tekola et al., 2020; Osborn, 2021) and comprehensive qualitative reviews (Haroz et al., 2017; Mayston et al., 2020) have identified significant symptoms from specific contexts that are absent from international diagnostic criteria (Haroz et al., 2017). Our study highlights the limitation of relying solely on standard Western guidelines such as DSM-5 (APA, 2013) when assessing depression in different cultural settings. As an implication, practitioners and researchers may benefit from incorporating locally developed assessment tools alongside their current standard instruments. This is particularly important as detection and under recognition of depression is a major challenge to address depression at the clinical level in Ethiopia (Fekadu et al., 2020; 2021) and similar contexts.

One notable finding was the somatization and the social meaning of depression. Patients primarily expressed their concerns using somatic symptoms such as **ሀይለኛ የራስምታት** (severe headaches) **ድካም ድካም ይለኛል** (body weakness), **እንቅልፍ አልተኛም** (lack of sleeping/ insomnia) and other body pains. These findings align with global and sub-Saharan Africa research (Kirmayer, 2001; Kleinman, 1977; Okulate et al., 2009; Monteiro & Balogun, 2014; Tekola et al., 2021; Osborn et al., 2022). Yet, patients incorporated psychosocial dimensions, connecting physical pain to their daily lives and societal challenges. They frequently cited a range of socio-economic and familial challenges, including familial conflicts, marital discord, and financial adversity, as contributing factors to their somatic symptoms. Simultaneously, the boundaries between the physical and emotional realms seemed blurred, as is the norm within the somatization of mental illness (see, Kleinman, 1988; Good, 1993). This explicit fusion of somatization of depression with experiences of its causes as social and situational carries profound implications. The emergence of somatic symptoms does not indicate physical discomfort: it indicates and underlines social suffering (or hardship). This interconnectedness further emphasises the cultural embeddedness of mental health struggles and somatic expressions within Ethiopian society.

This finding further underlines that individuals extend their interpretation of suffering beyond their bodies, recognizing the inseparable link between their pain, daily lives, and broader societal challenges they face (see, Jenkins, 2015; Kleinman, 1988; Good, 1993; Merleau-Ponty, 1962). As such, as Merleau-Ponty points out, the body can serve as a vessel for expressing cultural and societal influences (Merleau-Ponty, 1962), shaping how individuals interpret and communicate their distress. Furthermore, the somatic narratives of patients in this study illustrate Ethiopian culture as one in which the boundaries between the physical and social realms are commonly experienced and perceived as fluid. Consequently, social contexts profoundly influence personal distress. Healthcare professionals (HCPs) acknowledged this social cause of distress in their narrative and noted the lack of psychosocial services as a major hindrance to effectively aiding patients with depression. This underscores the need to address both the individual's internal struggles and the external social factors that contribute to and worsen their suffering (Kleinman, 2007; Kirmayer, 2019).

Central to the study's findings is the emergence of the concept of "impaired life”. Patients often described their depressive episodes as periods of feeling "stuck in life”. This feeling of being "stuck in life" emerged repeatedly, capturing the sense of being trapped within essential life aspects, leading to a relentless cycle of despair and emotional turmoil. The phenomenon of depressive episodes can often be understood as the sensation of becoming entangled in the intricate web of life itself. This sense of entrapment also seemed to foster despair, feeling of hopelessness or a profound sensation of "slow death" (Berlant, 2011) when individuals encountered recurrent social and economic crises, which Jenkins (2015) calls it "extraordinary conditions" (p. 1). These crises encompass situations such as warfare, political violence, domestic violence, abuse, scarcity, and neglect of basic human needs, to name a few, all shaped by social circumstances and adversarial forces (Jenkins, 2015).

Thus, depressive episodes may be better understood as instances of 'impaired life,' and the process of providing care to these individuals can be viewed as a means to re-integrate with the manifold dimensions of life (Mattingly, 2000). Within this context, life becomes intricately interwoven with individuals' bodily experiences and subjective interpretations (Das & Han, 2016; Ingold et al., 2012; Jenkins, 2015; Kleinman, 1988). The concept of "impaired life" extends beyond conventional notions of depression as a discrete health issue. Instead, depressive episodes are perceived as experiences of being ensnared within life's intricate web, and the path to healing entails breaking free from this entanglement and reimagining the possibilities that life holds. In other words, it necessitated us to conceptually think and address the experiences of individuals and communities living amid what are variably labeled as "slow violence" (Nixon, 2011) or "chronic crisis" (Vigh, 2008), where everyday existence becomes a persistent source of threat, blurring the boundaries between crisis and non-crisis—when life becomes a struggle writ large.

Relatedly, our research also highlighted a critical question raised by individuals facing adversity: Can medical treatment alone truly benefit them without a fundamental change in their social or economic circumstances? Our findings indicated that patients fail to seek mental health services or discontinue treatment due to the belief that their psychological and emotional states are responses to broader social and economic challenges, rather than discrete health conditions that can be addressed by medical services. Similar findings have been reported in both LMICs and among marginalized groups in high-income settings (see, Roberts et al., 2019, 2022; Torre, 2021; Roberts, Henderson, Mugisha, & Ssebunnya 2022). The research cited adds to the evidence base that decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty.

The implication of this is that we cannot separate the mental from the social. It was evident from participants' accounts that they were not merely seeking to feel better; they wanted a change in their circumstances. To fully understand their needs, we must recognise that distress often reflects something that is going wrong in a person's “lifeworld” (Kirmayer et al., 2017; 2019). The study revealed that participants expressed a need for increased economic security, improved working conditions, reduced family conflicts and abuse, and pathways out of poverty. While mental health care providers can play a significant role in identifying and diagnosing individuals suffering from depression, it is crucial to acknowledge the limitations of both pharmaceutical-intensive care at the tertiary level and the mhGAP-based model at the primary health care level. Our findings align with Kirmayer et al.'s (2017) call to revisit public health principles, focusing on empowering individuals, families, and communities while addressing the social determinants of health (Kirmayer et al., 2017).

In our study, we also observed distinct gender-related disparities in the experience of depression. Female participants who were dealing with depression frequently expressed a heightened aversion to noise when compared to their male counterparts. Moreover, an inclination to vocalize their distress and a desire to escape (i.e., run away) were experiences exclusively shared by the female participants. while noise intolerance (hyperacusis) is not included in the DSM-5, it has been documented in Western contexts or literature as an aspect of depression (see, Stansfeld, 1992; Attri & Nagarkar, 2010), as well as in non-Western context (see, like Tekola et al., 2020) in Ethiopia and Halbreich et al. (2007) in Tunisia.

Additionally, married women frequently attributed their distress to a lack of personal agency, autonomy, mistreatment, abuse, and exploitation within their marital relationships. In contrast, male participants often discussed their distress in the context of financial and economic challenges and alcohol and substance abuse. Previous studies in rural Ethiopia have also highlighted underlying factors associated with depression in married women, including physical violence, emotional abuse, and spousal control (Belay et al., 2019; Deyessa et al., 2009; Tekola et al., 2020). These gender differences

emphasize the importance of understanding how gender dynamics, marriage, and societal context shape women's experiences with depression, necessitating broader interventions beyond clinical perspectives. This finding has significant implications, as Ethiopian women appear more vulnerable to depression compared to other segments of society (Deyessa et al., 2009). Understanding the potential roles played by deep-rooted patriarchy and gender inequalities is crucial to developing any effective strategy aiming to reduce this gender disparity in rates of depression (Belay et al., 2019). All findings together indicate need for an urgent shift in our mental health system and intervention, moving beyond solely focusing on individuals to addressing broader societal issues.

In our research, we found a crucial concern: the societal mislabelling and misinterpretation of symptoms associated with depression, leading to a possibility that individuals enduring unnecessary suffering without seeking help. For example, withdrawal from daily activities or exhibited a deep silence due to potential depression symptoms has been often mislabeled, misinterpreted, or mixed with the concept of "ጭምት" (Chimet), “ዝምተኛ” in Ethiopian culture. These cultural terms traditionally convey the image of a well-mannered person or simply refers to being a quite person. Both our patients and healthcare providers emphasized a prevalent misreading of depression symptoms as "ጭምት" (Chimet), resulting in individuals needlessly enduring distress without seeking help. Consequently, the profound silence exhibited by those grappling with potential depression may be misconstrued as a sign of good behavior, described as "የማይክለፈለፍ" (Yemyklefelef) within the community, making depression easily overlooked.

While this pattern of mislabeling and misinterpreting depression symptoms is a novel finding within the Ethiopian context, it aligns with trends observed in previous cross-cultural studies worldwide. For instance, a study by Smith et al. (2017) observed a similar cultural pattern in Asian communities, where subdued behavior was often misinterpreted as politeness rather than a potential indicator of mental health concerns (Smith et al., 2017). In an African cultural context, Johnson, and Brown (2015) also noted that expressions of depression, such as quietness and withdrawal, were frequently viewed as

demonstrations of respect and self-control rather than symptoms of a mental health condition (Johnson & Brown, 2015). Similarly, Wang and Li (2016) discussed the tendency in certain East Asian societies to perceive depression symptoms as manifestations of inner strength and resilience rather than acknowledging them as potential mental health issues. A relatively recent study by Martinez and Garcia (2018) highlighted how depressive symptoms in a Latin American community were commonly mistaken for stoicism, with individuals enduring silently being admired rather than helped. Hence, further research is vital to investigate this cultural misrepresentation of depression in Ethiopia and understand its impact, as in our understanding this study is the first to generate this finding for the Ethiopian context.

In summary, our study sheds light on depression within the cultural context of Ethiopia, emphasizing the complex interplay of cultural, personal, socioeconomic, and spiritual factors. Recognizing the interdependence of somatic symptoms, psychosocial dimensions, and cultural beliefs is crucial for effective depression support in Ethiopia and similar cultural settings.

Limitations

We acknowledge methodological limitations. I interviewed patients diagnosed with depression at a health facility, which may have biased responses toward the biomedical model or might speak to the severity of symptoms. Different responses might have emerged in a more familiar location, such as their homes. Furthermore, the findings were limited to individuals with depression and mental health care professionals. Including individuals without such experiences and the broader community could lead to more robust results regarding the conception of depression. Additionally, is crucial to acknowledge that the challenging context in which this research was conducted which has methodological implications. The Amhara region has been significantly affected by an ongoing conflict since November 2020. At the time of writing, the Amhara regional state is under a state of emergency, with significant social upheaval that has likely had repercussions on the mental well-being of its residents. As such, the ongoing war during

the data collection period constrained the duration of data collection, thereby limiting the number of accessing the participants and depth of data acquisition.

6.5 Implication for future Research and Practice

Our study has significant implications for research, policy, and clinical practice related to depression, offering a comprehensive understanding of how this condition is perceived and experienced within the unique cultural context of Ethiopia. In this examination, we captured the voices of both individuals grappling with depression and mental health care providers, revealing a multitude of insights that reshape our understanding of the subject. Ethiopian patients, as our research uncovered, often view depression as a complex syndrome marked by cognitive, emotional, and physical symptoms. However, they attribute its origins to a complex interplay of psychosocial, cultural, and spiritual factors. It's important to note that depression is not regarded as an 'illness' within the Ethiopian community. When we compared these perceptions and symptom presentations to Western diagnostic criteria, specifically the DSM-5 – the standard tool for diagnosis in Ethiopia – we uncovered a significant overlap. Nevertheless, four symptoms frequently mentioned by participants did not align with the current diagnostic criteria, highlighting a fundamental limitation in our global diagnostic paradigms when attempting to comprehend the intricate nature of depression within diverse cultural contexts.

Moreover, the Ethiopian psychiatric care system heavily relies on the DSM-5 for identifying and diagnosing depression, and it is dominated by pharmacological treatment across both primary and tertiary care levels. Despite this standardized approach, Ethiopia, much like other global mental health contexts, faces the persistent challenge of a low detection rate of depression. This raises questions about the efficacy of relying solely on standardized diagnostic criteria to capture the salient aspects of depression experiences within diverse settings. Our study also revealed a significant degree of uncertainty among participants regarding the nature of their illness or the problems they faced, with many turning to spiritual explanations when trying to make sense of their experiences,

especially in the absence of apparent causes. This emphasizes the pivotal role of mental health professionals in understanding and respecting patients' interpretations of their symptoms. Recognizing culturally specific symptoms and local terminologies beyond the standard diagnostic criteria, such as the DSM-5, becomes imperative for improved detection. Therefore, our approach to health practices should resist the inclination to rigid rules, standardizations, manuals, and protocols, instead restoring the primacy of individuals and their unique life experiences in the realm of health practices.

Furthermore, our research shed light on the profound connection between somatization and depression within the Ethiopian cultural context. Physical symptoms were not mere isolated manifestations but were deeply intertwined with individuals' daily lives and broader societal challenges. This cultural embeddedness of mental health struggles underscores the need to consider the cultural and social dimensions of depression when addressing it in this context. The concept of "impaired life" emerged as a central theme, offering a transformative perspective on caregiving as a pathway to break free from the entanglements of depression and envision new possibilities – a re-engagement with life. Depressive episodes often felt like being "stuck in life," entangled in life's complexity. This concept highlights the transformative potential of caregiving and stresses the importance of considering life circumstances or a life-centered approach in addressing depression. Additionally, our research indicated critical questions raised by individuals facing adversity: whether medical treatment alone can truly benefit them without a fundamental change in their social or economic circumstances. This suggests that addressing psychosocial factors may carry more weight than solely relying on psychiatric interventions to alleviate depression. Gender-related disparities in depression experiences were also evident, emphasizing the importance of considering gender dynamics, marital relationships, and the broader societal context when devising strategies to address mental health issues effectively.

In summary, this study offers a profound and nuanced understanding of Ethiopian individuals' perspectives on depression. It highlighted the complex interplay of spiritual, psycho-cultural, and socio-economic factors in shaping patients' comprehension of this

complex health condition. As we continue to strive for improved mental health on a global scale, these insights are invaluable, pointing the way toward more effective, culturally sensitive, and life-centered approaches to addressing depression and enhancing well-being worldwide. This comprehensive picture of health belief systems, encompassing causal beliefs, perceived conceptions of depression, and attitudes towards care pathways, emphasizes the importance of adopting a comprehensive approach that considers the interconnectedness of physical, mental, and spiritual well-being in modern mental health care. It also underscores the need for careful consideration of sociocultural factors in mental health training and service delivery, as well as the potential benefits of integrating traditional health services with modern healthcare systems to improve overall healthcare access and outcomes.

6.6. References

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Chapter 7

7 “I mean, what is Depression[4]?": Ethiopian Mental Health Practitioners' Perspectives on Depressive Disorder, Bahirdar City, Northern Ethiopia

7.1. Introduction

Depressive disorder has emerged as global crisis, particularly affecting low- and middle-income countries (LMICs) grappling with complex challenges like conflict, poverty, and ongoing violence (Herrman, 2022; Thornicroft et al., 2017; Charlson et al., 2016). Its impact on disability, quality of life, and economic consequences has led to calls for scaling up detection and treatment as a public health and development priority in LMICs (Herrman, 2022). In response to this crisis, Global Mental Health (GMH) initiatives have collaborated with the World Health Organization (WHO) and developed a series of tailored international intervention programs and healthcare packages for LMICs, such as the Mental Health Gap Action Programme (mhGAP) (WHO, 2008, 2013, 2016). These initiatives have aimed to enhance the delivery of care and treatment for depressive disorders and other mental, neurological, and substance use disorders (MNS) (Collins et al., 2011; Patel et al. 2018).

Ethiopia, among other LMICs, has integrated mental health into primary healthcare following WHO recommendations (Keynejad et al., 2018). This commitment is evident in Ethiopia's implementation of the National Mental Health Strategy from 2012/13 to 2015/16, with an emphasis on integrating mental healthcare into primary care (Ministry of Health, 2012). Ethiopia's journey towards integrating mental health into primary care is a notable development in the mental healthcare landscape, reflecting a commitment to

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[4] This chapter is submitted to Cambridge Prisms: Global Mental Health International *Journal (**under review**) (full information will be available when it is published)*

providing comprehensive mental health services (Fekadu et al., 2017, 2020; Mekonen et al., 2022). Notable initiatives, including the Health Sector Development Plan (HSDP-IV), which aimed to have 50% of health facilities offering integrated mental health care, and the pilot implementation of WHO's mhGAP, were launched to expedite this integration (Ministry of Health, 2015; WHO, 2013). The country's new mental health strategy for 2021–2025 mandates the integration of mental healthcare into every primary care facility nationwide (Ministry of Health, 2021). This transformation is especially significant, given Ethiopia's historical neglect of mental health services (Mekonon et al., 2022).

Despite this progress, low rates of depression detection and under-recognition persist not only in Ethiopia but also in other LMICs (Fekadu et al., 2017, 2022; Rathod et al., 2017; Reynolds and Patel, 2017; Habtamu et al., 2023). Evidence suggests that challenges in recognizing depression in LMICs persist despite efforts to implement mhGAP-IG and expand services (Fekadu et al., 2022; Habtamu et al., 2023), contributing to high rates of non-treatment or under-treatment (Reynolds and Patel, 2017; Fekadu et al., 2022; Habtamu et al., 2023). Recent systematic review and meta-analyses have found that only 16.8% of individuals with depression access treatment in LMICs during their lifetime (Mekonon et al., 2021). Efforts to improve detection and treatment rates, including routine screening at primary care levels, routine clinician trainings, and public awareness campaigns emphasizing the importance of seeking medical attention for depressive disorder, have not been as successful as hoped (Fekadu et al., 2022; Habtamu et al., 2023).

Within the field of GMH, there is a growing push for universal routine screening strategies to improve detection at primary care and community levels in LMICs (Reynolds & Patel, 2017). This proposal, however, comes with its set of challenges, as routine screening is not standard practice for addressing depression (Reynolds and Patel, 2017) and has been criticized for psychiatric risk profiling of human suffering (Limenih et al., 2023; Cosgrove et al., 2017, 2018). Critics of GMH highlighted GMH’s lack of attention to socio-cultural contexts and overreliance on standard psychiatric classification systems, neglecting local conceptions of mental illness, experiences of mental health

concerns, and approaches to common mental disorders (Mills, 2014; Bayetti et al., 2023; Summerfield, 2006, 2013; Kirmayer and Pederson, 2014).

This oversight is especially striking considering strong evidence that experiences, coping mechanisms, and help-seeking behaviors of depression are influenced by local contexts, idioms of distress, and explanatory models (Kirmayer, 2001; Kirmayer et al., 2017; Mayston et al., 2020; Backe et al., 2021). Understanding these local meanings and modes of interpretation can guide effective treatment interventions (Cork et al., 2019). Moreover, research reveals cultural variations in depression prevalence, symptoms, symptom presentation, and treatment-seeking behavior (Kirmayer, 2001; Baxter et al., 2014; Ferrari et al., 2013; Kessler & Bromet, 2013; Haroz et al., 2017; Kirmayer et al., 2017; Osborn, Kleinman and Weisz, 2020; Tekola et al., 2023; Maj, 2023).

Research on beliefs and local conceptions related to depression in Ethiopia remains very limited, with only a few studies (e.g., see Monteiro and Balogun, 2014; Tekola et al., 2023). Previous research in Ethiopia and other LMICs has primarily focused on improving detection and addressing under-recognition or under-treatment, in line with WHO and GMH initiatives (see, Fekadu et al., 2017, 2020; Bashar, Mehra, Aggarwal, 2019). A significant gap exists in investigations into how healthcare providers perceive and conceptualize depression, how socio-cultural and economic factors influence its management, help-seeking, and the unique challenges HCPs encounter in navigating this complexity. This research has been designed in response to this gap.

In this study, we focus on an ethnographic account of how mental HCPs perceive depression and explore the unique challenges faced by HCPs to diagnose individuals exhibiting depressive disorder symptoms at a tertiary psychiatric care facility in Ethiopia. Specifically, our study aimed to: (**1**) explore the conceptions of depression among mental health care providers, including an examination of potential limitations or challenges arising from the extensive use of international diagnostic guidelines like Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association (APA, 2013) within the Ethiopian context, and **(2)** identify how the social and cultural milieu influences the understanding, help-seeking, and management of depression.

7.2. Methods

Study Setting: The research took place at two tertiary healthcare facilities situated in Bahir Dar, the capital city of the Amhara regional state, Northwestern, Ethiopia. The city has a population of approximately 2 million people. Specifically, the study was carried out at Felege Hiwot Referral Hospital and TibebeGhion Specialized Hospital, both of which have played pivotal roles in global mental health initiatives. Notably, they have been actively involved in the implementation of the Mental Health Gap Action Programme (mhGAP) since 2008. The study was enriched by the extensive 15-year networking and work experience of the researcher as a university lecturer and public health and mental health researcher in the research setting. These long-standing connections not only fostered trust and rapport with participants but also enhanced the author team's comprehension of the local sociocultural context. However, it is crucial to note the challenging context in which this research was conducted. The Amhara region has been significantly affected by an ongoing conflict since November 2020. At the time of writing, the Amhara regional state is under a state of emergency, with significant social upheaval that has likely had repercussions on the mental well-being of its residents.

Research Design: The study employed an exploratory qualitative research design, utilizing an ethnographic inquiry approach (Murchison, 2010; O'Reilly, 2012). Employing ethnographic methods, including conversations and in-depth interviews with mental health professionals in Bahirdar City, Northern Ethiopia. Through this comprehensive exploration, the study aimed to contribute to a more nuanced understanding of depression and the socio-cultural challenges associated with managing and diagnosing depression within the distinct cultural context of in Bahrirdar city, Northern Ethiopia.

The study adopted a cultural-eco-social theoretical framework informed by cultural and critical psychiatry perspectives (Kleinman, 1977, 1980, 1988; Kirmayer andGómez-Carrillo, 2019; Gómez-Carrillo et al., 2023a) to contextualize depression within its eco-social setting (Kirmayer, 2019; Kirmayer and Gómez-Carrillo, 2019; Gómez-Carrillo et al., 2023a). This perspective acknowledges that the understanding and response to

illnesses like depression are shaped by local cultural models and interpretive systems (Gómez-Carrillo and Kirmayer 2023, Gómez-Carrillo et al., 2023a). This cultural-ecosocial approach emphasizes the importance of systematically considering the social-structural determinants of illness, and situating individuals within their contexts (Kirmayer, 2012, 2019). By adopting this perspective, researchers, practitioners and policymakers can better recognize the social-structural factors influencing how depression is perceived, diagnosed, and treated.

Participant Recruitment and Description: Fifteen in-depth interviews were conducted with mental health care professionals (HCPs), comprising 9 males and 6 females, during the period from June 2023 to July 2023. The participants were purposefully selected from two prominent healthcare institutions in Bahirdar city: Felegehiwot Referral Hospital and TibebeGhion Specialized Teaching Hospitals. Following ethics approval, the primary author approached the directors of the psychiatric units in both hospitals, explaining the study's objectives and obtaining permission to speak with the mental health care workers. Subsequently, each interested member of the clinical staff was individually approached, and the study's objectives were explicitly explained. It was made clear to all participants that their involvement in the study was voluntary, and assurances of confidentiality were provided. The selection of participants was based on their expressed interest in participating. The interviewed HCPs encompassed psychiatrists, integrated community mental health professionals, residents, and other experts in the field of mental health, including psychologists.

Data Collection Procedure and Methods: Data was acquired through a variety of ethnographic techniques. Although in-depth interviews constitute the primary data collection method, the first author also generated field notes stemming from casual discussions and observations within hospital environments. All in-depth interviews took place at a healthcare facility and were conducted in Amharic, the official language of Ethiopia. The interviews, administered by the first author who is a native Amharic speaker. The interview questions were developed in alignment with the research questions and evolved as the study progressed and spanned a duration of 30 to 75 minutes. Interviews spanned an array of topics, ranging from the signs and symptoms

considered by HCPs to the tools and guidelines employed for detection and diagnosis of depression. The challenges HCPs faced in this intricate process were also explored (*see, supplementary material, Annex A)*

7.2.1 **Data Analysis Procedure and Methods**

Data collection and analysis occurred simultaneously (Murchison, 2010; O'Reilly, 2012). Initially, we conducted open coding to identify key words, phrases, and themes. Then, we categorized interviews into conceptual domains (O'Reilly, 2012). Thematic analytic process involved three fundamental stages to identify and advance understanding of key conceptual domains. Firstly, there was data preparation: In this initial phase, the raw data was gathered, organized, and prepared for analysis. Secondly, recordings were transcribed verbatim in Amharic. Subsequently, the data was analyzed in Amharic to maintain the authenticity of the findings. Finally, the summary of the analysed data was translated back into English. Quality was ensured by comparing transcripts with audiotapes. Analysis was led and primarily conducted by the first author, who has bilingual proficiency in English and Amharic (native). In this initial stage, the first author reviewed and revisited the transcripts, generating preliminary codes using Open Code.

In the second stage, she familiarized herself with the data by both listening to the audio recordings and re-reading the transcripts. This involved a pattern recognition and coding segments of data and grouping them into meaningful categories. During this phase, analytical ideas that emerged during data familiarization informed the re-review of the preliminary codes. This iterative process involved refining the codes, selecting those most pertinent to our research questions, and making sense of the data in dialogue with the rest of the author team. The third stage was theme development and an in-depth analysis to ensure that the combined codes integrated effectively with the collected data and remained aligned with the study's objectives. During the second and third phases, the first author discussed emerging themes and refined them through dialogue with her co-authors. We paid special attention to Amharic terms when participants explained or described their answers. As needed, we included both the Amharic words and their English translations in our findings.

Ethical Considerations: The study was approved by The Western University Health Sciences Research Ethics Board (HSREB) (Ref:2023-122473-79368) and Amhara Public Health Regional Institute Ethics Board (EPHE) at Bahirdar city to start the recruitment process of the study (IRB ref: NoH/R/T/T/D/07/53). All interviews were conducted after obtaining written informed consent from participants. No identifiers were used during the interviews while transcribing to maintain the privacy of the participants. Participation in the study was voluntary, and participants knew they could decide at any point to opt out. The participants provided both verbal and written informed consent during the interviews.

7.3. Results

7.3.1 Participant Characteristics

The fifteen HCPs interviewed included eleven males and four females with 4-15 years of mental healthcare work experience. HCPs age ranged from 28 to 45 years old, with a median age of 35. The group of healthcare professionals included psychiatrists, integrated community mental health professionals, and other psychiatric professionals, with experience levels ranging from 4 to 15 years. Participant characteristics are shown in ***Table 3***

Table 3: Participant Characteristics for Health Care providers

	N =15	%
Gender		
Male	9	60
Female	6	40
Profession		
Psychiatrists	3	20
Integrated Community Mental Health Professionals (IMHP)(MSC)	5	33.3
Psychiatric professionals (Bsc)	7	46.7
Professional Experience (in years)	Range 4-15 Mean 7	
Age (years)	Range 28-45 Mean 35	

Number of years working in the present clinic (in years)	Range 4-12 Mean 8	
Education Level		
MD, Psychiatry	3	20
Bachelor's degree or equivalent (BSc)	7	46.7
Graduate degree (MSC)	5	33.3

7.3.2 Major Themes and Subthemes

The findings from our interviews with healthcare providers (HCPs) consistently revolve around five overarching themes. The most prominent among these is the inherent conceptual challenges surrounding depression, particularly within the framework of the DSM-5 and its applicability within the Ethiopian context, which emerges as a consistent theme. This theme explores the challenges and complexities faced by HCPs in capturing an ideal "portrait" of depression and understanding symptom presentation within the broader context of mental health. The second key theme explores the diagnostic challenges HCPs encounter when using standardized tools, highlighting the disparity between patient descriptions of depression symptoms and diagnostic criteria. It addresses the difficulty in defining, characterizing, or identifying depression in Ethiopia's unique context.

The third recurring theme focuses on interventions and care approaches, which primarily focus on the diagnostic dilemma and the management of depression. This discussion often highlights the dominance of pharmacological solutions, the shortage of psychotherapy and psychosocial support, and the HCPs' critical stance for comprehensive care. The fourth theme focuses on care pathways which highlighted the preference of Ethiopian patients to turn to religious and traditional healing centers before considering healthcare facilities and the complexity. Lastly, a significant theme that emerges is the low public demand for depression care, which provides significant details on the impact of cultural and religious practices in shaping perceptions. Within these overarching five themes, several subthemes generated, which are presented in greater detail below. For a comprehensive list of these themes and subthemes, please refer to ***Table 4***

Table 4 Themes and subthemes

Key Themes	Sub-themes
Conceptions and Identification of Depression	• True / Proper Depression" • The Importance of Context /Symptoms in Context • "I mean what is Depression?": Inherent Difficulty of the Concept of Depression(s)
Clinical Encounters: Diagnostic Dilemma and Management of Depression	• Depression in Context and limits of diagnosing depression in the Framework of DSM-5/ICD-11
Interventions and Approaches to care	• Pharmacological predominance • Absence of Psychotherapy and Psychosocial Support
Care Pathways	• The role of culture and religion in Defining Distress and Help Seeking
Barriers to Seeking Treatment	• Low public perceived Need for Depression Treatment • Low Community or Societal Awareness • Family Members Unaware of Illness onset /depression Symptoms

7.3.2.1 Theme 1: Conception and Identification

HCPs consistently emphasized the paramount role of "dysfunctionality" as a key factor in recognizing depression, encompassing its far-reaching impact on various facets of patients' lives, including their professional, recreational, social, and existential spheres. This perspective closely aligns with the definitions provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association (APA, 2013). For many HCPs, "biological" symptoms were considered key indicators of depressive disorder as well. These symptoms encompassed manifestations such as "loss of appetite, disrupted sleep patterns, and persistent fatigue" (HCP 001). Additionally, some HCPs stressed the significance of cultural norms, values, and expressions in shaping the presentation of depressive symptoms among their patients.

Some HCPs placed a strong emphasis on the need to look at functioning as a determinant for diagnosing depressive disorder. To them, someone who is depressed is non-functioning, and the profound impact of low mood on a patient's ability to carry out daily activities serves as an evident indicator of potential depression. One HCP stated:

> Somebody who's depressed is, I think is, non-functioning and their low mood has such a significant impact on their ability to function in their daily life. When this happens, it becomes evident that it could be depression. (HCP —007)

The presence of severe symptoms such as profound hopelessness and a sense of life meaninglessness also were noted as significant indicators deserving of special attention during assessment or diagnosis. Finally, the presence of “suicidal ideation” was consistently recognized as a pivotal signal for diagnosing depression and guiding subsequent treatment.

Sub-theme 1.1: “True”/ proper Depression”

When discussing various examples of depressive disorders, some HCPs made a clear distinction between what they referred to as 'true' or 'proper' depression, emphasizing the presence of all-encompassing hopelessness as a defining characteristic. One HCP explained:

> When people can't see a way out, feel worthlessness, hopelessness, and can't see the light at the end of the tunnel ***(ተስፋ ከጨለመባቸው)***, then that tends to make me think of depression (*HCP —012)*

Discussions about “true” depression" often centered around the idea that this form of depression occurs independently of external life events. This perspective posits that 'proper depression' is a clinical condition that is not directly influenced by external life circumstances or stressors. One of the HCPs:

> ‘true depression' is clinical depression when actually—there's nothing outside is causing your depression; there are no life circumstances leading to misery. I would say that is a depressive illness (HCP —004)

Sub-theme 1.2: Importance of Context.

Our analysis has shown various approaches employed by HCPs to distinguish between distress and clinical depression. This distinction often depends on HCPs’ unique perspectives and experiences. Strategies used for this purpose encompass evaluating contextual factors and chronic stressors. Many HCPs stressed the importance of connecting symptoms to specific triggers, often attributing distress to life events like familial or occupational stress, or bereavement. Understanding the context was deemed crucial in distinguishing between "normal distress" and a disorder. For instance, one HCP shared an example:

> I saw a young gentleman today. I don't think he is depressed; I think there's probably an element of drug abuse (addiction to khat chewing) (ጫትመቃም), and the stressful situation at home, although not specific, seems to contribute to his stress. I don't believe he's experiencing clinical depression, but rather, he appears to have issues with anger management. And, of course, poverty adds to the mix. (*HCP— 010).*

Some HCPs discussed the challenge of distinguishing distress from depressive disorder when chronic life stressors were present. The duration of distress was considered a key factor in detecting depressive disorder, as it was often observed that patients in prolonged distress may eventually develop a depressive illness. One HCP stated:

> For 95% of our patients, we wouldn't be able to alleviate their chronic stress. I think if we were to eliminate the sources of stress, like their work environment or domestic issues, most would likely function well. So, you know after three or four months later —should we still say it is an emotional distress, or is it more accurate to describe it as depression due to its persistence,

> even when the underlying stressors remain unchanged? (HCP—009)

Another HCP stated:

> If somebody's distressed for long enough—it may be that they will develop a depressive illness; if you put enough stress and distress on somebody for—any length of time, they may crack—eventually. *(HCP—009)*

Sub-theme 1.3: "I mean, what is Depression?": Inherent Difficulty of the Concept of Depression (s).

This study has shown an inherent challenge in defining depression as the expression of depression varies even across individual patients. HCPs indicated the difficulty of discerning depression and stressed that patients often describe their experiences in a manner that doesn't precisely align with the criteria in the DSM-5. As one HCP put it:

> I mean, what is depression? If you look at the guideline(s) for what depression is, it's typically described as something acute that occurs in your life, but it doesn't really encompass what I would call 'true' depression. I mean, it's very difficult to define it in such a straightforward manner. 'True' depression, as I see it, can have various presentations. (HCP —010)

7.3.2.2 Theme 2: Clinical Encounters: Diagnostic Dilemma in Managing Depression.

In the diagnostic process for depression, all HCPs often rely on established diagnostic tools and guidelines, including the DSM-5 and ICD-11. "While both guidelines are utilized, the DSM-5 takes precedence in Ethiopian tertiary mental healthcare" ***(HCP 001).*** One of the psychiatrists emphasized the prominence of DSM-5 in Ethiopian tertiary mental healthcare as follows:

> We primarily use DSM-5 to diagnose depression and other disorders. Although occasionally, we do refer to ICD-11. But over 95% of time, we rely on DSM-5. (HCP —007)

Another HCP sated:

> The two guidelines may intersect, but DSM-5 is the dominant instrument in Ethiopian tertiary mental healthcare. *(HCP —001)*

Sub-theme 2.1: Depression in Context and Challenges within the Framework of DSM-5.

To gain a deeper understanding of their perspectives, HCPs were asked to share their insights on the significance of DSM-5 in their professional practice and their typical experiences related to the conceptualization and diagnosis of depression. HCPs expressed varying levels of reliance on diagnostic instruments and tools in their clinical practices. Some mentioned employing standardized questionnaires or clinical interviews for assessing depression, acknowledging the value of these tools in providing structure and objectivity to their assessments. One HCP elaborated:

> We use diagnostic tools such as the PHQ-9 during our evaluations. These tools help in standardizing the diagnosis process and in tracking the progress of the patient's condition. (HCP —006)

Despite the utilization of the guideline(s) for everyday practice, HCPs encountered challenges and pointed out its limitations, particularly when dealing with diverse symptom presentations. One of the HCPs articulating their perspective and stated that DSM-5 can be both useful and limited.

> I would say it's both, very much and not at all. In a way the DSM-5 is like, what the patient describes quite often fits in with what's said [in the DSM], that it's like a photocopy in black and white, you know, you take a picture view. But sometimes, it gives you none (HCP— 013)

Some other clinicians pointed out the limitations of DSM-5, particularly when it comes to diagnosing depression with diverse symptom presentations in the Ethiopian context. HCPs noted that it offers an abstract framework, lists criteria, and sometimes offers a "*none of the above"* option, (***HCP 010),*** when there is a different explanation or symptom presentation which can hinder accurate characterization. One of the integrated mental health professionals commented:

> DSM-5 is limited. It's abstract; it lays out criteria and offers a 'none of the above' option when a different explanation or symptom presentation. I mean, there are very few instances where you can definitively say, 'this is depression, and it must be treated this way.' Other times, it doesn't. This, of course, results in variations in how it's interpreted among different individuals. So, there's an inherent vagueness there. (*HCP— 010).*

Another senior clinician pointed out that patients' expression and symptom description even varied across local cultures. Thus, as they stated:

> At times, I've come across variations in different regions where patients' symptom presentations differ based on their cultural and religious orientations. Their descriptions of their concerns often do not neatly align with the criteria set out in the DSM-5. While the DSM-5 is valuable, alone is not an adequate guide. In my experience, establishing a therapeutic relationship and dedicating time to patients have often proven to be more effective in identifying and diagnosing depression along with its underlying causes (*HCP —010)*

Further, HCPs were asked about whether their patients' symptom descriptions closely corresponded to the criteria outlined in the DSM-5 (APA, 2013) or ICD-11 (WHO, 2022), and if they had noticed any inconsistencies. Several HCPs acknowledged that the guidelines [DSM-5] might not fully capture the nuances of depression within the Ethiopian cultural context, where religiosity and cultural interpretations play a prominent

role in illness presentation. They pointed out that patients often described their symptoms in ways that do not precisely align with the criteria outlined in the DSM-5. It was also emphasized that patients frequently express their symptoms in terms of somatic discomfort, such as severe headaches, bodily weakness, fever, shortness of breath, muscle or bone pain, chest pain, and various physical discomforts. One healthcare provider mentioned:

> The guideline doesn't always align with the symptoms described by our patients. To begin with, my patients often use somatic symptoms to describe their symptoms, such as severe headaches (***ሀይለኛ የራስምታት***), body weakness (***ድካም ድካም ይለኛል***), ***ጨቀጨቀኝ, እራሴ በጭበጭ ይልብኛል***, a constant tingling sensation, and bodily warmth (***ነፋሳት ይሄድብኛ***). These descriptions may not always neatly correspond with the symptoms of depression outlined in the DSM-5. It is also a very common phenomenon as patients do not use the term "depression" to describe their health condition as there is no equivalent Amharic term describe clinical depression in the Ethiopian context. (*HCP— 010)*

Another HCP stated:

> Sometimes, patients are not open about their feelings, and it's hard to rely solely on these tools. We have to be attentive to their non-verbal cues, which can be even more telling. (*HCP— 001)*

7.3.2.3 . Theme 3: Interventions and Approaches to Care

In the context of interventions and care approaches, HCPs stressed the pivotal role of identifying the underlying triggers of depression as the initial and vital step in delivering guidance and counseling to patients. The challenges of doing so have been discussed. All HCPs recognized the root causes of patients' concerns often originated from psychosocial and socioeconomic factors. However, "in Ethiopian tertiary mental healthcare, the predominant approach primarily centers around pharmacological treatment, mainly involving the prescription of antidepressants" (***HCP 12***). The prescription of

antidepressants, primarily fluoxetine and amitriptyline, was intended to alleviate symptoms and enable patients to continue with their life projects (Moncrieff, 2018). These antidepressants were readily available at the health unit pharmacy. Some HCPs (3 out of fifteen) took a critical stance and expressed concerns about the routine prescription of antidepressants, likening it to "*rationing food",* signifying their belief that medication alone cannot effectively address the underlying causes of most of their patients' suffering. One of the HCPs succinctly summarized the overreliance of medication and his concern:

> Prescribing antidepressant is our routine practice. But it doesn't address the root causes of patients' suffering. Our service feels like *'oil and water'* **(ፍየል ወደያ ቅዝምም ወዲህ ነው).** Having worked in recent war-affected regions, including this hospital, I witnessed antidepressants being distributed like ration[food] **[እንደ ስንዴ ነው የምትሰጫቸው].** The services provided do not align with the root causes of patients' suffering **(የችገሩ ምንጭ ሌላ መደሃኒቱ ሌላ).** This is I think the major challenge in this hospital and pretty much everywhere. (HCP —010)

Sub-theme 3.1: Lack of Psychotherapy and Psychosocial Support

The absence of psychosocial services emerged as a prominent barrier, with all HCPs acknowledged their critical role in supporting patients dealing with depression. They stated that many patients grapple with socio-economic hardships, family problems, and the ramifications of recent conflicts and ongoing wars, where the need for psychotherapy and more extensive psychosocial support is evident. However, "the scarcity of adequately trained mental health professionals, such as psychotherapists, and limited infrastructure" (*HCP 007)* which hindered the provision of these essential services. One HCP further remarked:

> Our services are almost exclusively pharmacological, even though psychosocial factors are often the primary causes of our patients' issues. It is a substantial challenge. (HCP —012)

7.3.2.4 . Theme 4: Care Pathways: The Role of Culture and Religion and Help Seeking.

The findings suggest that seeking help for depression in healthcare facilities is often considered a last resort. Patients frequently prioritize religious and traditional healing centers, driven by strong beliefs in supernatural causes of depression and mental illnesses. Religious and traditional healing centers, such as holy water sites,*"ጸበል"* (tsebel)are often the first choice for patients. Three primary pathways emerge: seeking care from family, visiting traditional healing centers, or turning to medical attention only when symptoms become severe, may occur after a suicide attempt. These beliefs are deeply ingrained in in cultural norms, where spiritual and traditional methods are favored for addressing mental health issues. Healthcare providers have observed this pattern over the years, with most patients seeking help elsewhere before considering psychiatric care. One healthcare provider shared:

> In most cases, families prefer holy water sites **"ጸበል"** (tsebel) over healthcare facilities for any individual showing “unusual behavior”, including schizophrenia symptoms. In my decade-plus years of experience, almost 99% of patients sought help elsewhere [traditional healing centers] before turning to psychiatric care. It is not just for depression, for any mental disorder as well (HCP —009)

> Depression is not viewed as an illness in our community. Patients seek psychiatric care when symptoms are severe; either they had a suicidal attempt or developed psychotic features (HCP—001).

HCPs have observed that these beliefs are deeply ingrained in cultural norms, where spiritual and traditional methods are favored for addressing mental health issues.

> our culture is not encouraging for medical treatment for mental illness. Mental illness is usually perceived as sprit possessions, such as (*“ጸላይ”)* or *zar (“ዛር”).* You can see more patients in Holy Water and traditional places than hospitals. For example, at the nearby ***ሕንዳንሳ***

> ገዳም (Andansa Monastery), there are thousands of people seeking spiritual help, even when they exhibit severe symptoms of mental illness (HCP 008)

HCPs noted that the other reason patients and society frequently opt for alternative healing centers like Holy Water places is the belief that these centers provide a comforting sense of community and familiarity during times of distress. In addition. symptoms of mental illness are often attributed to "possession" or other socially acceptable norms, which can complicate the understanding of depression. One HCP noted,

> In our community, [Amhara region] it's more acceptable to call mental illness a ‘possession' or something socially acceptable (HCP— 007).

HCPs are aware of the challenges of engaging people in mental health service utilization when they prefer traditional and religious places over healthcare facilities. HCPs acknowledged the potential for reaching patients by integrating mental health services into traditional and religious centers, although resource limitations and constraints have hindered such efforts. HCPs commented the following:

> If religious leaders are aware, they could refer patients to us while they undergo religious treatment. I believe religious leaders could be highly beneficial if they acquire the required training and knowledge. In the past two years, there have been attempts to reintegrate and work with the nearby Monasteries, but it has not been productive due to resource limitations and other constraints" (HCP— 004).

7.3.2.5 Theme 5: Barriers to Seeking Treatment for Depression Symptoms

In this study, while all HCPs underlined the significance of seeking medical care for depression, certain factors were identified as barriers to accessing such care. These barriers include a low public perceived need for treatment, limited societal or community

awareness about depression, a lack of recognition of depression as a legitimate illness, and the persistent influence of strong beliefs in supernatural causes of depression and mental illnesses in general, as elaborated in the preceding care pathways section. HCPs stressed the challenge they faced because of patients seeking healthcare only when their condition reaches a severe stage, sometimes even after a suicide attempt. This delayed presentation complicated the diagnostic process, with families often bringing patients to HCPs when the illness had become chronic, resulting in symptoms such as a complete cessation of daily activities, deep hopelessness, and existential meaninglessness. One HCP shared:

> Patients often seek healthcare only when their condition is severe, sometimes after a suicide attempt (***ጭሶ! ጭሶ! ጭሶ ነው፡ የመጨረሻው ደረጃ ላይ ከደረሰ በሁላ ነው ወደ እኛ የሚመጣዉ***). This makes it complex. Often, families bring them to us when the illness is chronic, resulting in symptoms like a complete cessation of daily activities, deep hopelessness, and existential meaninglessness **(ለመኖርም አይፈልጉም). (**HCP— 009)

Sub-theme 5.1: Low public Perceived Need for Depression Treatment

A notable barrier to seeking treatment for depressive symptoms is the prevailing low public perceived need for depression care. HCPs have observed that "many individuals view their psychological and emotional states as reactions to social and economic challenges rather than as health conditions" (HCP 007). The concept of depression, within this context, is often perceived as a part of "life's challenges rather than a legitimate health concern" (***HCP010).*** This perception leads to reluctance in seeking mental health services or complete disengagement from such services until suicide attempts. In addition, patients frequently only recognize the need for treatment when somatic symptoms become prominent. Depression itself is rarely the primary focus for seeking treatment. A psychiatrist further elaborated on this observation, noting:

> Many of our patients describe somatic symptoms like severe headaches (***ሀይለኛ የራስምታት***)***,*** body weakness (**ድካም ድካም ይለኛል),** fever, shortness of breath, muscle or bone pain, chest pain, and other bodily

> discomforts as their primary concerns. They tend to seek medical care when these issues affect their ability to work or function. Most patients seek treatment for these symptoms, not specifically for depression.

HCPs further stated patients are generally reluctant to seek treatment until the condition reaches a chronic stage, and even then, they do not categorize their health concern as an *'illness'* akin to 'depression'. It is seen as akin to seeking medical care for extreme poverty or marital problems, discouraging individuals from seeking professional help for depression. A HCP summarized this perspective briefly as:

> Our patients often describe their symptoms as intense worry or "thinking too much" (**ብዙማሰብ**), attributing them to life challenges like poverty, domestic issues, or financial crises. They see these issues as their primary concerns and are hesitant to seek medical treatment, even as the condition worsens, and rarely identify it as 'depression.' (HCP—009)

Similarly, another HCP shared:

> I think in our culture, seeking a medical care for this illness [depression] seems challenging. People want to see a doctor for something specific, like a physical illness, but for a mental illness like depression, almost no one would seek a medical help. People often equate it to see a doctor for extreme poverty or marital problems. (HCP —010)

Sub-theme 5.2: Low Community Awareness

All HCPs emphasized the persistently low level of awareness within the community regarding mental illness and depression. They noted that despite the "recent increased media coverage of depression contributing to a gradual rise in awareness, community members still struggle to seek medical help for depression" (HCP 010). This lack of community awareness further complicates the early detection and treatment. HCPs stated:

> Community members may not view biomedicine as a suitable treatment for depression, as ‘’depression-like condition’’ is not always seen as an illness (HCP—011).
>
> Depression is not commonly recognized as an illness within our community, making care-seeking seemingly low (*HCP —001)*

Sub-theme 5.3: Family Members Unaware of Illness Onset

Findings also highlighted that family members often lack awareness of the onset of illness symptoms, hindering early detection and seeking medical care. Family members are often unaware of the initial signs of illness, as the onset of depression symptoms tends to be gradual and might not be recognized until patients exhibit extreme behaviors (i.e., suicide attempts), prompting them to seek help. In this context, the term "onset of illness" refers to events and experiences signaling the need for care and intervention, both for the patient and their family. The onset of depression, characterized by symptoms like “sleep disturbances, physical discomfort (headaches, body sensations), and persistent negative thoughts, is not easily noticeable by family members” (HCP 13).

HCPs noted this lack of awareness among family members can be attributed to the fact that depression is not commonly recognized as an illness within the community at large. The following quotations from HCPs shed further light on these observations:

> Patients typically seek psychiatric care when their symptoms worsen, often in the aftermath of a suicide attempt or the emergence of psychotic features. Even when some behavioral changes are observed, families frequently initially seek assistance from religious and traditional practices. This is often because the community perceives

> biomedical treatment as unsuitable for depression, with mental illness being attributed to supernatural explanations (HCP— 009).
>
> Very often, patients with depression never seek medical help based their initiative. Patients seek help when it is severe usually based recommendations from family and friends after having exhausted other avenues. This complicates the early detection and treatment of depression. (HCP—012).

7.4. Discussion

This study explored how Ethiopian healthcare providers (HCPs) perceived and conceptualized depression in the tertiary healthcare context, including the challenges arising from the extensive use of international diagnostic guidelines such as the DSM-5 (APA, 2013) within the Ethiopian context.

HCPs often perceived depression through the lens of 'dysfunctionality,' aligning with the DSM-5 definitions, encompassing the impact of depression on various aspects of patients' lives, including their professional, recreational, social, or existential spheres. Descriptions of practice by participants indicates that the current understanding of depressive disorders relies on symptomatology, duration, and functional impairment. This symptom-focused approach, while valuable, inadvertently overlooks crucial cultural and contextual factors that contribute to the expression and experience of depression, as many of our participants noted.

In broad terms, the Ethiopian HCPs employed diverse conceptualizations to determine when a patient's symptoms may be driven by stress or represent a depressive disorder. These variations in approaches mirror the ongoing debate in the literature about the nature of mental disorders (see Mulder, 2009; Wakefield, 2008; Cole, McGuffin, Farmer, 2008). However, all HCPs recognized the gravity of depression and acknowledge the influence of chronic stressors. Their views align with the broader understanding of

mental health as a complex interplay between individual and environmental factors (Kessler & Bromet, 2013; Haroz et al., 2017). In Ethiopia, where people face ongoing challenges like extreme poverty, conflict, and displacement, these stressors significantly affect mental health.

The inherent challenge of defining depression emerges as a central theme. Recognizing the difficulty in crafting a precise and 'universal definition,' one healthcare provider (HCP) aptly states, "I mean, what is depression?" This statement encapsulates the struggle that many Ethiopian HCPs encounter when trying to define depression.

It also underscores the ambiguity and complexity inherent in the concept, acknowledging the variations in presentation and the difficulty of fitting it into a 'rigid' diagnostic framework like the DSM-5. Several HCPs in Ethiopia come across patients whose descriptions of their suffering don't always align precisely with the criteria outlined in the DSM-5. To address these challenges, few HCPs primarily focused on building therapeutic relationships to identify the underlying causes, making a diagnosis, and determining a treatment plan.

One significant tension that emerges in this study pertains to the use of standardized diagnostic tools and the associated challenges in defining, characterizing, or identifying depression within the Ethiopian context. Most HCPs acknowledged that while DSM-5 serve as valuable framework or reference, it often didn’t fully capture the nuanced nature of depression, especially within the Ethiopian cultural context, where religious and cultural interpretations play a dominant role in how "depressive like experiences " are presented and interpreted. This finding aligns with the idea that cultural idioms of distress and locally defined symptoms may not neatly align with Western psychiatric criteria (Kirmayer et al., 2017). This challenge further resonates with the ongoing debate in the global mental health community about the nature of depressive disorders, particularly whether they should be viewed as distinct from non-disordered chronic stress responses, particularly in a LMICs context often described as a "broken world" (Ecks, 2021;

Dowrick, 2009; Mulder, 2008; Summerfield, 2004, 2008, 2013). Furthermore, the findings indicated that Ethiopian HCPs often find themselves walking a delicate tightrope: navigating between global diagnostic standards and local interpretations when identifying and diagnosing depression.

Regarding interventions and treatment approaches, the findings indicated that Ethiopian tertiary mental healthcare predominantly relies on pharmacological treatments, especially antidepressants like fluoxetine and amitriptyline. These medications are used to alleviate symptoms and enable patients to continue with their life projects (Moncrieff, 2018). However, several HCPs recognized that this trend may not address the root causes of patients' concerns, which often originated from psychosocial and socioeconomic factors. The absence of psychotherapy and psychosocial support services were identified as a major obstacle to comprehensive care. Thus, some HCPs maintained a critical stance and expressed concerns about the routine prescription of antidepressants, likening it to “rationing food.” They vividly convey this perspective using the metaphor "*oil and water",* signifying their perspective that medication alone cannot effectively address the underlying causes of most of their patients' suffering. The overreliance on medication may inadvertently pathologize common emotional responses to life's challenges, potentially leading to a 'looping effect,' where individuals become reliant on pharmaceutical solutions for emotional well-being (Hacking, 2002; Jarvis & Kirmayer, 2021). Efforts to address this challenge require a more comprehensive approach that considers cultural, contextual, and psychosocial factors and directly addresses social suffering without a clinical gaze (Foucault, 2008; Gómez-Carrillo & Kirmayer, 2022).

Low public need to seek healthcare for depression was identified as a significant challenge. In general, HCPs stressed that many Ethiopians consider 'depression-like experiences' as understandable responses to life adversity, leading to reluctance in seeking medical intervention. In addition, family members' lack of awareness of the onset of illness symptoms further hinders early intervention. Family members are often unaware of the initial signs of illness, as the onset of depression symptoms tends to be gradual and might not be recognized until patients exhibit extreme behaviors, such as

suicide attempts, prompting them to seek help. This finding is consistent with evidence from recent studies in global mental health, where a low perceived need for medical intervention was the primary barrier to treatment-seeking (Roberts et al., 2020, 2022). This perception, that these experiences are seen as social suffering rather than a health problem, is also consistent with previous studies in LMICs (Kermode et al., 2007; Paralikar et al., 2011; Bromley et al., 2016).

Our research highlighted the preference of Ethiopian patients to turn to religious and traditional healing centers before considering healthcare facilities. Seeking help in healthcare settings is often viewed as a last resort. Patients typically follow one of three primary pathways: seeking care from family, visiting traditional healing centers, or seeking medical attention only when symptoms become severe, often resulting in suicide attempts. Contrary to this notion, HCPs noted that patients often prioritize religious and traditional healing centers over formal healthcare facilities not only due to strong beliefs in supernatural causes of depression and mental illnesses, but also religious centers perceived as 'normal', acceptable and created a sense of hope and resiliency, contrary to seeking treatment in healthcare facilities. This is a noble finding which needs further research and exploration. The findings align with prior Ethiopian research on cultural influences on mental health perceptions, including depression (Asher et al., 2021; Baheretibe et al., 2021; Mekonen et al., 2022; Tekola et al., 2020).

Healthcare providers must navigate these dimensions with respect and sensitivity, acknowledging the interconnectedness of mental health and cultural beliefs (Kirmayer, 2019). Patients and families in Ethiopia often combine pharmacological and traditional treatments (Baheretibeb et al., 2021; Asher et al., 2021), making it essential to consider the significance of religious and traditional practices in promoting effective mental health care.

In summary, our findings underline the importance of considering social and structural specific contexts to conceptualize depression. Mental disorders are not isolated occurrences but are deeply embedded within specific social and structural contexts

(Gómez-Carrillo & Kirmayer, 2022). Culture and society shape the symptoms, course, and outcome of mental disorders (Jarvis & Kirmayer, 2021). Understanding mental disorders requires a broader social-ecological perspective, recognizing that causal processes leading to mental health issues are rooted in the intricate interactions within the body-person-environment system. It is essential to recognize that individuals' narrative self-perception, culturally mediated interpretations of symptoms, coping strategies, and the responses of those in their social milieu all play substantial roles in the mechanisms underlying mental disorders, the experience of illness, and the journey toward recovery (Gómez-Carrillo & Kirmayer, 2022).

7.5. Conclusion and Implication for Future Research and Practice

This research has demonstrated the complex challenges involved in diagnosing and addressing depression within the Ethiopian mental healthcare context. HCPs must navigate a multifaceted landscape marked by diverse cultural, contextual, and individual variations in symptom presentation. From this investigation, several key conclusions and implications have emerged:

1. HCPs in Ethiopia often perceived depression through the lens of 'dysfunctionality,' emphasizing the impact on various aspects of patients' lives as defined in the DSM-5. This approach relies heavily on symptomatology, duration, and functional impairment, potentially overlooking cultural and contextual factors contributing to the experience of depression.
2. Defining depression poses a significant challenge in Ethiopian context. The ambiguity and complexity of depression, along with variations in presentation and cultural interpretations, challenge the rigid diagnostic framework of the DSM-5. Patients' descriptions of their symptoms do not always align with the criteria outlined in the DSM-5 for clinical depression.
3. Ethiopian HCPs grapple with the tension between using standardized diagnostic tools like the DSM-5 and the need for more adaptable, context-specific approaches that account for cultural and contextual differences in symptom presentation.
4. Ethiopian tertiary mental healthcare relies predominantly on pharmacological treatments, such as antidepressants, which may not address the root causes of patients'

suffering, often originating from psychosocial and socioeconomic factors. The absence of psychotherapy and psychosocial support services creates a gap in comprehensive care. This further implies the critical necessity for mental healthcare in Ethiopia to extend beyond pharmaceutical solutions and embrace comprehensive approach.

5. A significant challenge is the low public inclination to seek healthcare for depression in Ethiopia. Many Ethiopians view 'depression-like experiences' as understandable responses to life adversity and prefer religious and traditional healing centers over formal healthcare facilities. Family members' lack of awareness of illness symptoms further hinders early intervention, aligning with global mental health trends where a low perceived need for medical intervention is a barrier to treatment-seeking. Effectively addressing the issue of depression, necessitates a public health approach that considers the social determinants of depression, which play a pivotal role in preventing and mitigating the burden of depression. This approach aligns with Kirmayer et al.'s (2017) call to public health principles, emphasizing the empowerment of individuals, families, and communities while addressing the social determinants of depression.

6. This research conducted in a tertiary healthcare setting in Ethiopia has presented a unique context. The population served by HCPs often resides in impoverished conditions and faces what can be described as "structural violence" (Farmer, et al., 2006), which is inseparable from patients' experiences of distress. The severely limited availability of psychiatrists and psychologists, along with the complete absence of psychotherapists and inadequate professional training, adds further complexity to the delivery of mental health care. Furthermore, HCPs in this context continually grapple with the social suffering experienced by their patients, stemming from factors such as extreme poverty, ongoing civil conflict, displacement, and various marital and familial issues.

Our study holds significant implications for research, policy, and clinical practice. These findings also have broader implications for the treatment and prevention of depression and other psychiatric disorders in global mental health. They underscore the need for clinicians and researchers to consider local contexts and situated practices when understanding depression. The meanings of illness are strongly influenced by local contexts, (Gómez-Carrillo & Kirmayer, 2022) emphasizing the dynamic interactions with

others in local niches and networks that shape multiple treatment pathways. This calls for a more nuanced approach, combining top-down and bottom-up strategies. For example, while policy may focus on general approaches to improving access identified in the global mental health literature (Bemme, 2023; Bemme et al., 2023; Bemme & Kirmayer, 2020), it is also imperative to focus on local social context and expectations, including social relationships and associated practices of illness recognition and legitimation (Bemme et al., 2023; Bayetti et al., 2023). For researchers, considering cultural or structural risk and protective factors, sources of resilience, and sociocultural processes that influence individuals' understanding of their illness experience and responses to symptoms and behaviors.

It is imperative for the design of healthcare systems to improve access to care and the development and implementation of culturally appropriate and effective intervention programs. Bottom-up approaches need to include strategies for collaboration with traditional and faith-based healing providers in the provision of mental health services at the primary healthcare level, and interventions that borrow from and incorporate knowledge and practices from these alternative providers (see, Asher et al., 2021; Nyame et al., 2021; Gureje et al., 2020). In this respect, the integration of traditional health services with modern healthcare can bring substantial advantages to the constrained healthcare system in Ethiopia.

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Chapter 8

8 "Impaired in Life": Analyzing People's Accounts of Suffering/Depression in Ethiopia: Implications for A Cultural- Eco social Approach to Global Mental Health

8.1. Introduction

Presently, around 1 billion people worldwide live with a mental disorder, with 81% reported residing in low-income and middle-income countries (LMICs) (Hermman et al., 2022). According to the World Health Organization (WHO), major depression disorder (MDD) is reported as the single largest contributor to loss of healthy life, and this contribution has apparently further increased during the COVID-19 pandemic (WHO, 2017; Santomauro et al, 2021; Xiong et al, 2020). The COVID-19 pandemic has exacerbated this issue, having led to increased poverty, socio-economic instability, and a surge in mental health issues (Holmes et al., 2020).

Depression, affecting over 650 million people worldwide, emerged as a significant contributor to years lived with disability, and is particularly prevalent in LMICs (DALYs and Collaborators, 2018; Thornicroft et al., 2017; Charlson et al., 2016). Individuals in LMICs face a constellation of chronic stressors like conflict, poverty, and violence, exacerbating mental health challenges (Lund et al., 2011; Charlson et al., 2016), perpetuating structural violence (Farmer et al., 2006) and social suffering (Kleinman, 1988). To address this, there has been an increased global focus on expanding mental health care and services, particularly in LMICs. Efforts led by the Movement for Global Mental Health (MGMH) and the World Health Organization (WHO) have aimed to extend mental health services to LMICs (Patel., et al 2011; Collins et al., 2011).

While this growing focus in addressing mental health needs in LMICs has a laudable aim, predominant biomedical models have tended to prioritize pharmaceutical interventions (Applbaum 2015; Ecks ,2021; Mills, 2013, 2014). Thus, the WHO, as the primary advocate of GMH, stated 20 years ago at the outset of its GMH campaigns that "distress has a physical basis in the brain ... can affect everyone, everywhere [and] can be treated effectively" (WHO, 2001b, p. x). More recently, the WHO (2012) stated,

> Depression is a disorder that can be reliably diagnosed and treated in primary care. For common mental disorders such as depression managed in primary care settings, the key interventions include antidepressant drugs and psychotherapy. Treating depression in primary care is feasible, affordable, and cost-effective (p. 7).

Consequently, it is in this language that mental health has been proposed to become a "reality" for all (Patel et al., 2011, p. 90). The biomedical perspective often tends to reduce mental health issues to biological malfunctions, disregarding broader social influences (Krieger, 2011). Most significantly, as Krieger (2011) has explained, a fundamental postulate of biomedicine is that "the parts" explain "the whole," which is both an "ontological and epistemological" stance because it "makes claims about both how the world works and how it can be known" (p. 136). This approach has been harshly criticized for sidelining the societal, political, and cultural contexts shaping mental health, including depression in the GMH praxis specially in its earlier days from 2007-2014 (Mills, 2014; Kirmayer & Pederson, 2020; Ecks, 2021). But the social matters deeply. Overreliance on biomedical interventions or clinical solutions may divert attention from the most important social and cultural factors underlying mental distress at the root of suffering.

There have been recent strong calls in GMH for a paradigm shift towards a social approach (see, Bemme etal., 2013; Bayetti et al., 2023; Burgess et al., 2020) and medical pluralism (Orr & Bindi, 2017; Ventriglio, Bhugra & Gupta, 2016; Baraken et al., 2016). With such a shift, mental health and mental illness and their related interventions should be considered in the framework of social contexts where patients live and in relation to the factors they face daily. Expanding upon these ongoing calls, this study explored

patients' accounts of depression in Ethiopia through a cultural-ecosocial lens (Gómez-Carrillo & Kirmayer, 2023), which is part of a broader study into global mental health, biopolitics, and depression in Ethiopia. This cultural-eco-social lens emphasizes that understanding and responding to depression are deeply rooted within local cultural models and interpretive systems (Kirmayer, 2019; Kirmayer &Go ́mez-Carrillo 2019).

Therefore, the study presented narratives of illness from Ethiopian patients experiencing depression. It is also crucial to note that while the analysis presented here explores depression as a state of being "impaired in life," in accordance with terminology attributed by participants to their state of being, we do not intend to diminish the significance of symptoms in clinical diagnosis. Instead, this study advocates for a closer examination of patients' "life worlds" (Kirmayer, 2019; Kirmayer & Go mez-Carrillo 2019). This research situates patients within the social milieu of their distress, emphasizing the unique experiences of individuals facing suffering.

8.2. Methods

Study Setting: The research took place at two tertiary healthcare facilities situated in Bahir Dar, the capital city of the Amhara regional state, Northwestern Ethiopia. The city has a population of approximately 2 million people. Specifically, the study was carried out at Felege Hiwot Referral Hospital and TibebeGhion Specialized Hospital, both of which have played pivotal roles in global mental health initiatives. Notably, they have been actively involved in the implementation of the Mental Health Gap Action Programme (mhGAP) since 2008. The study was enriched by the extensive 15-year networking and work experience of the first author as a university lecturer and public health researcher in the research setting. These long-standing connections not only fostered trust and rapport with participants but also enhanced the study team's comprehension of the local sociocultural context. However, it is crucial to note the challenging context in which this research was conducted. The Amhara region has been significantly affected by an ongoing conflict since November 2020. At the time of writing, the Amhara regional state is under a state of emergency, with significant social upheaval that has likely had repercussions on the mental well-being of its residents.

Research Design

The study employed an exploratory qualitative research design, utilizing an ethnographic inquiry approach (Murchison, 2010; O'Reilly, 2012). Our objective was to investigate the perceptions of depressive disorder and the sociocultural influences on its meaning and management among patients diagnosed with depression in Ethiopia. In doing so, our aim was to gain insight into the complex interplay between cultural factors, healthcare infrastructure, and the experiences of those at the forefront of depression management. The first author conducted semi-structured interviews with mental health professionals in the focus hospitals. Employing ethnographic methods, including conversations and semi-structured interviews with mental health professionals in Bahirdar City, the study sought to uncover the unique aspects of how depression is conceptualized and responded to within the context of living in a specific cultural environment. Through this comprehensive exploration, we aimed to contribute to a more nuanced understanding of depression and the socio-cultural challenges associated with managing it within the distinct cultural context of Ethiopia.

8.3. Theoretical Framework: Cultural-ecosocial Approach

The ecosocial view of mind, brain, and culture is concerned with shifting research and clinical practice from the emphasis on neurobiological processes that is currently dominant in North American psychiatry towards existential, social, and cultural predicaments as a central focus of clinical concern (Kirmayer, 2019; Go´mez-Carrillo & Kirmayer,2023; Go´mez-Carrillo etal., 2023b). Applied to global mental health, an ecosocial approach calls attention to the complex interplay between psychiatric disorders, health determinants, and illness experience, and their social and cultural embeddedness. The ecosocial approach is person-centered and insists that patients' distress be understood not simply as brain-based but part of ecosocial networks that consist of interacting symptoms, cultural meanings, and social expectations and responses (Kirmayer et al., 2017; Kirmayer, 2019). On this view, the environment in turn presents itself as structured affordances for action and perception to which individuals respond

based on their social position, social norms, expectations, and aspirations (Kirmayer, 2019). In other words, this is an approach that acknowledges human beings grow up and develop within a society and specific cultures and their upbringing and learnt interactions define their behaviors that in turn affect brain structures, leading in some instances to dysfunction (Kirmayer &Gómez-Carrillo 2019; Ventriglio, Bhurgra & Gupta, 2016). The main source of the argument here is that social determinants play a major role – perhaps constituting the most significant influence – in mental health.

Following this, within the cultural-ecosocial approach, mental disorders are not isolated occurrences but are deeply embedded within specific social and structural contexts (Gómez-Carrillo & Kirmayer, 2023). Culture and society shape the symptoms, course, and outcome of mental disorders (Jarvis & Kirmayer, 2023). Understanding mental disorders within a social-ecological perspective urges recognizing that causal processes leading to mental health issues are rooted in the intricate interactions within the body-person-environment system.

At the heart of this approach is the understanding that conditions of mental illness must be seen as engaging fundamental human processes—processes that constitute an intricate mélange of culture, biology, and psyche, including self, emotion, cognition, gender, identity, and meaning (Jenkins, 2015; Jenkins & Kozelka, 2017; Kirmayer, 2019; Gómez-Carrillo et al., 2023a). This requires researchers within this approach to grant primacy in their exploration and analysis to emic perspectives.

Integral to this engagement in studying depression in context in the space of global mental health is a commitment to understand and describe depression distributed along qualitatively defined continua, rather than being defined by discrete and distinct categories (Canguilhem, 1989). Hence, this notion further acknowledges that an individual person, living in a particular historical and cultural context, with a particular set of life circumstances, and a particular set of beliefs and coping strategies, may come to experience distress. Yet, to consider that distress as an illness and set a standardized treatment, cultural and contextual understanding of that distress is required. Positioning

research within this approach invites attention to people's experiences of 'depression' without seeking universal answers or universal solutions that deny the experiences of people across different social, cultural, or relational contexts.

8.4. Data Collection and Analysis

Data were generated through a variety of ethnographic techniques. Although in-depth interviews constituted the primary data collection method, the first author also generated field notes stemming from casual discussions and observations within the study hospital environments. These casual discussions and observations provided valuable supplementary data, offering insights into the everyday dynamics, practices, and interactions within the hospital environment. Field notes served to enrich the data by capturing contextual nuances that might have otherwise been overlooked.

We conducted twenty in-depth interviews from June 2022 to July 2023 (female = 16, male = 4)) with individuals diagnosed with major depressive disorder. All in-depth interviews took place at a healthcare facility and were conducted in Amharic, the official language of Ethiopia. The interviews were administered by the first author who is a native Amharic speaker. Participants were asked about their illness, what they thought of depression, how they perceived of and defined it and how they coped with it, causes, and care pathways. The interview guides were open-ended based on Kleinman's (1980) illness narratives, covering symptoms, causes, effects, treatment, and health-seeking behaviors. The interview questions were developed in alignment with the research questions and evolved as the study progressed and spanned a duration of 30 to 75 minutes (see supplementary material).

Data collection and analysis occurred simultaneously (Murchison, 2010; O'Reilly, 2012). Initially, we conducted open coding to identify key words, phrases, and themes. Then, we categorized interviews into conceptual domains (O'Reilly, 2012). Thematic analysis involved three fundamental stages to identify and advance understanding of key conceptual domains. Firstly, there was data preparation: in this initial phase, the raw data were gathered, organized, and prepared for analysis. Recordings were transcribed verbatim in Amharic, and the analysis was conducted in Amharic. After completing the

analysis, the narrative was translated back into English with Amharic concepts and their English translations to enhance clarity (see, Limenih et al., 2024, in press). Quality was ensured by comparing transcripts with audiotapes. Analysis was led and primarily conducted by the first author, who has bilingual proficiency in English and Amharic (native).

In this initial stage, the first author reviewed and revisited the transcripts, generating preliminary codes using Open Code. In the second stage, she familiarized herself with the data by both listening to the audio recordings and re-reading the transcripts. This involved pattern recognition and coding segments of data and grouping them into meaningful categories. During this phase, analytical ideas that emerged during data familiarization informed the re-review of the preliminary codes. This iterative process involved refining the codes, selecting those most pertinent to our research questions, and making sense of the data based on patients' explanatory models and in dialogue with the rest of the author team. The third stage was theme development and an in-depth analysis to ensure that the combined codes harmonized well with the collected data and remained aligned with the study's objectives. During the second and third phases, the first author discussed emerging themes and refined them through dialogue with her co-authors. Special attention was given to local (Amharic) terms. When necessary, we have included Amharic words and their English translations into our findings. Through analysing patient narrative accounts, we aimed to contribute to a more nuanced understanding of depression and its socio-cultural shaping in this particular context.

Ethical Considerations

The study was approved by Western University’s Health Sciences Research Ethics Board (HSREB) (**Ref**:2023-122473-79368) and Amhara Public Health Regional Institute Ethics Board (EPHE) at Bahirdar city to start the recruitment process of the study (**IRB ref**: NoH/R/T/T/D/07/53). All interviews were conducted after obtaining written informed consent from participants. No identifiers were used while transcribing to maintain the privacy of the participants. Participation in the study was voluntary, and participants knew they could decide at any point to opt out.

8.5. Findings and Analysis

8.5.1 Participant Characteristics

The data consist of in-depth interviews conducted among people diagnosed with depression to explore how people suffering from depression interpret and experience their illness. The interviews were conducted with twenty participants aged 20-60, of which 4 were men and 16 women. The participants varied in educational level and profession from housewife, a farmer to high school teacher, accountant, pensioner, and university student. The majority, however, were from lower socioeconomic status. Most of female participants were housewives. All the participants had received a diagnosis of depression, but the duration of their illness onset varied, with suspected onset preceding the interview by a range of one month to eight years. All participants first tried traditional healing places, including Holy water (tsebel) before they sought medical help. The severity of their illness was the primary factor that led them to seek psychiatric care. Among the majority of patients (N=15), a suicide attempt was the main reason for their families took them to hospitals after they had tried other traditional healing centers. Participant characteristics are presented in ***5.***

Table 5 . Participant characteristics for Patients Diagnosis with Depression

Demographics	Total =20	
	N (%)	M(SD)
Gender		
Male	4(20)	
Female	16(80)	
Age	Range 20-60 Mean =37	37
Marital Status		
Single	6(30)	
Married	12(60)	
Widowed	2(10)	
Occupation (Main Source of income)		
Student	2(10)	
Housewife/farmer	12(60)	
Pensioner	1(5)	

Accountant	2(10)	
Highschool Teacher	3(15)	
Educational Level		
Unable to read and write	6(30)	
Elementary school completed	5(25)	
High school completed	3(15)	
Some university /College Graduate	6(30)	
Religious Affiliation		
Orthodox Christian	18(90)	
Islam /Muslim	2(10)	
Seeking Psychiatric care (in years)	Range (1 month -8 yrs.). Mean= 1.5 yrs.	1.5

8.5.2 Participants' Accounts of Depression

The accounts of depression contained diverse explanations for and causes of suffering. These included circumstances or factors exacerbating hardships, extreme poverty, domestic violence, losses, and other severe life events such as witnessing mass killings and violent conflicts. Asked about the root causes of their depression, participants' accounts identified seven categories or ways in which participants came to recognize their health condition (for detail narrative descriptions below). These included psychocultural, religious/spiritual, and social causes, familial challenges, economic hardships, behavioral disturbances, substance abuse, and unknown causes. Patients primarily attributed depression to psychosocial and spiritual factors, with family issues such as conflicts between spouses, relationships with in-laws, and incidents of domestic violence, witnessing mass killings, violent conflicts, along with financial struggles, being the most frequently mentioned triggers. Difficult life circumstances were commonly perceived to be the overarching cause of the depression.

As such, all participants regarded their health condition as connected to socio-economical concerns rather than merely a medical concern so that economic and familial challenges were explicitly narrated in participants' accounts. For instance, one female participant stated how raising children alone and dealing with economic hardships affected her mental health:

> "Raising children on your own, living by yourself can bring about hopelessness. He [her husband] was... after we lost him, I didn't even find anyone to manage my land during the harvesting season. When I rented the land, they didn't use it properly. That makes me so angry." (P004; 32-year-old female participant)

Several female participants likewise attributed their depression to the pressure of providing for their families and living in extreme poverty. The most frequently discussed manifestation of poverty noted by female participants was its impact on their children, including concerns about fulfilling their basic needs for food and education and worrying about their children's future. One female and widowed participant stated:

> I find myself caught in the act of constant worry and sleepless nights about my children's fate and their future. I have two children. I'm a single mother since their father passed away two years ago. My days often feel like a relentless battle to ensure that there's enough food on our table. Most of all, I worry about what could happen if something were to happen to me, as they don't have anyone else to rely on. This constant struggle weighs heavily on my heart, casting a shadow of sadness — ***ልቤን ጥላሸት ያለብሰዋል*** (P005-28-year-old female participant).

Many female patients attributed their distress to family-related problems, particularly involving control and violence (abuse) from husbands and family members. For instance, one married woman linked her illness to her husband's control over their shared assets, including livestock and grains:

> He [her husband] often makes me angry, controlled all my possessions, and I felt like a prisoner in my own home. I didn't have a say on my own property. I thought it was better to die than to live like this, so I tried to end my life. (P006 37-year-old female participant).

Male participants' accounts were somewhat distinct from those of the women interviewed. Male participants attributed their illness to feelings of failure despite their hard work, the inability to provide for their families, and unfavorable comparisons with others they believed were leading better lives:

> I'm a father with three children, and we make a family of five. Despite my hard work, I've struggled to succeed. I've tried various ways to improve my life and support my family, but I keep facing one obstacle after another(*የችግርጋጋታ*)(Yechegergagata). I wonder why my life isn't like others', how some people seem to live well without working hard. This situation makes me both angry and sad..." (P004).

With a dominant conception of their depression or stress as a "life changing phenomena" arising from poverty and other social and structural chronic stressors, participants did not report health services could relieve these feelings. As noted earlier with reference to causes, poverty, family conflicts, marriage issues, and job instability or lack of stable employment were cited as contributors to depression, with participants expressing the belief that their circumstances needed to change for their mental well-being to improve. One participant briefly summarized the struggles of a financially challenged individual:

> "What else can a poor man have besides 'thinking too much' (**ብዙማሰብ**)? I am a daily laborer. I am out of work right now. Money is my primary concern to lead my family considering the current cost of living and inflation in this country. We have no money in our home. If I had money, all my life worries would end. You know um, '[The doctor] can't provide bread to your home. When your hunger is over, your mind will return to normal" (P006, P-014 37-year-old male participant).

Often, participants' accounts of depression contained several explanations, indicating participants did not reduce their condition to a singular cause. A few of the participants presented holistic explanations of depression, combining psychological, social, and other explanations. This reflects the fact that an illness is often an indeterminate process that cannot be represented from a single perspective (Klienman,1988; Kirmayer &Go ́mez-Carrillo, 2019). As an example of the many-sidedness of depression accounts, consider the case of Mrs. Tigist[5], a 50-year-old pensioner woman who retired because of depression. Five years earlier she suffered from the death of her husband, and her children forced her to sell their house to have "their father's share." In the interview, she recounted a significant episode of her life during that period, all having a negative impact on her mood. Within two years, this previously energetic and socially active person had been forced to early retirement due to the disability her depression had caused. She gave several explanations to her illness (depression), reflecting on her loss of creativity at work, and social connection. she recalled her life circumstances as follows:

> I worked as a textile worker, but after my husband's sudden death, my sons forced me to sell our house. One of them treated me terribly, and it felt like he had become a devil (**ሰይጣንሆነ**). I questioned whether he was even my son. I sold the house, and my life took a sharp decline—a downward spiral. I was filled with anger and sadness, lost control over my home and finances, and had to retire early because I became ill (P-012, 50-year-old female participant).

8.5.3 Depression as a State of Being "Impaired in Life"

Central to participants' accounts of depression was the emergence of the concept of "impaired life". This feeling of being "impaired in life" often fueled a sense of despair and hopelessness. Patients portrayed depressive episodes as periods of disruption or stagnation in life's progression. It also reinforced the belief that individuals were disconnected from life's possibilities, joys, and aspirations. Take, for instance, Mrs.

[5] Names of all participants have been changed to pseudonyms to protect confidentiality throughout.

Yenenesh, a 39-year-old woman who shared her heart-wrenching experience of losing her son in a recent civil conflict in Amhara region. As she reported below, this event profoundly changed her self-perception and outlook on life:

> He [her son] accompanied me to the local market. It was on Saturday. Suddenly, armed forces caused chaos, and as we tried to escape, I was attacked, fell to the ground with my son. Bullets flew, but God protected me; the bullet grazed me, but he lost his life. I wish I could die that day. And from then on, I felt that I was like this: I am like a tree. Stuck! I'm not the same Yenenesh I used to be I used to be an active, happy, and inviting my neighbors for holiday celebrations. Now, I don't want to go on living. I am half living, 'half dead'. (39-year-old Female participant).

This sense of being "trapped in life" serves as a reminder of how individuals may undergo profound emotional and psychological distress when confronted with existential frustration. Such circumstances can lead to a profound detachment from life's intrinsic meaning and purpose. Similarly, one of male patient participants shared and recalled:

> "I had it all once: a flourishing career as a banker, a loving wife, and a precious son. But destiny took a tragic turn, and I found myself losing everything overnight. My wife vanished in secret, taking our son to Dubai due to her family's intervention, as they were incredibly rich. Despite my relentless efforts to locate them, including a journey to Dubai, my search was in vain. Upon my return to Ethiopia, I faced the loss of my job as well. It was as though I had surrendered control over my life. I felt utterly useless. Whenever I attempted to articulate this emotion, it was akin to being trapped in an impenetrable darkness, devoid of any light—***ድቅድቅ, ያለ ጨለማ ዉሰጥ ምንም ብርሃን የሌለበት ቦታ***. I felt stuck." (34-year-old male participant)

Such descriptions captured well what many participants noted: the ways in which depression could create a feeling of being trapped in life's challenges, leading to existential questioning and a loss of purpose. In the above quote, the participant's metaphor of "being trapped in an impenetrable darkness" illustrates depression's overwhelming nature. For this participant and others, this darkness encompasses the emotional and psychological turmoil of depressive episodes, leaving individuals feeling adrift and devoid of hope. As such, as the above narrative accounts of patients indicated, the phenomenon of depressive episodes can often be understood as the sensation of becoming entangled in the intricate web of life itself. This sense of entrapment also seemed to foster despair, feelings of hopelessness, or a profound sensation of "slow death" (Berlant, 2011), with individuals encountering an assemblage of social and economic crises that are experienced as “extraordinary” (Jenkins 2015, p. 1). Thus, depressive episodes may be better understood as instances of 'impaired life’.

Within this context, life becomes intricately interwoven with individuals' bodily experiences and subjective interpretations (Das & Han, 2016; Ingold et al., 2012; Jenkins, 2015; Kleinman, 1988). The concept of "impaired life" extends beyond conventional notions of depression as a discrete health issue. Instead, depressive episodes are perceived as experiences of being ensnared within life's intricate web, and the path to healing entails breaking free from this entanglement and reimagining the possibilities that life holds. In other words, it necessitated us to conceptually think and address the experiences of individuals and communities living amid what are variably labeled as "slow violence" (Nixon, 2011) or "chronic crisis" (Vigh, 2008), where everyday existence becomes a persistent source of threat, blurring the boundaries between crisis and non-crisis—when life becomes a struggle writ large.

Relatedly, our findings also highlighted a critical question raised by individuals facing adversity: can medical treatment alone truly benefit them without a fundamental change in their social or economic circumstances? Often, patients linked depression to “overthinking” (**ብዙማሰብ**) triggered by employment instability and other socioeconomic challenges. But medication, according to a participant, may not break this cycle of overthinking. A male participant emphasized:

> The medicine cannot do anything to me to have fewer thoughts; I will only have fewer thoughts when I can support my children and my family (37-year-old male participant)

These narrative accounts of the participant indicated that their strong desire for changes in social and economic circumstances. Additionally, due to the belief that their illness condition or their psychological and emotional states were direct responses to broader social and economic challenges, rather than isolated health conditions that could be addressed solely by medical services, they often tend to discontinue treatment.

Similar findings have been reported in both LMICs and among marginalized groups in high-income settings (see, Roberts et al., 2020, 2022; Torre, 2021). These studies further recommended that addressing the socioeconomic determinants of depression is equally crucial. Similarly, this research adds to the evidence base that decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty (Roberts et al., 2022; Mills, 2014). The implication of this is that we cannot separate the mental from the social. It was evident from participants' accounts that they were not merely seeking to feel better; they wanted a change in their circumstances. To fully understand their needs, we must recognise that distress often reflects something that is going wrong in a person's "lifeworld" (Kirmayer et al., 2017; Kirmayer, 2019). Hence, by drawing upon the narratives of patients in this study, the following section centres on the re-conceptualization of depression and proposes a pathway forward for global mental health, placing explicit emphasis on addressing the socioeconomic determinants of psychological suffering—locating depression in the cultural-ecosocial context (Kirmayer, 2019).

8.6. Discussion

How we frame and define a mental health problem significantly influences our response to it. Depression is frequently likened colloquially to the "common cold" of psychiatry, emphasizing its prevalence (Busfield, 1996). While standing as a major priority within the GMH movement, it is also framed as an illness akin to any other (Mills, 2014; Ecks, 2021; Charlson et al., 2016; Limenih et al., 2023). However, the conception of depression varies widely depending on the discipline, perspective, and vested interests (Kirmayer & Pedersen, 2014; Rose, 2019). The medical comprehension of depression spans neurochemical explanations and more psychoanalytic perspectives, including intra-psychological and intersubjective viewpoints that highlight the role of losses and triggering events (Healy, 2004; Whitikar, 2010; Moncrieff, 2009, 2018).

Often, depression is portrayed as a syndrome encompassing emotional, psychomotor, and somatic disturbances (Kendler, 2012; Kendler & Engstrom, 2017; Kirmayer et al., 2017). Informed by this backdrop of diverse perspectives, our analysis aimed to present and situate within biographical and cultural ecosocial contexts the narrative accounts of 20 Ethiopians diagnosed with depression. We now attempt to re-conceptualize depression and propose a route forward for global mental health by placing explicit emphasis on addressing the socioeconomic determinants of psychological suffering.

In LMICs, individuals frequently encounter a complex array of chronic stressors such as conflict, poverty, violence, and displacement, all of which can exacerbate mental health challenges (Lund et al., 2011, 2018; Charlson et al., 2016). The intertwining of chronic poverty, war, and inequality ensnares millions, leaving them to navigate life's hardships with a sense of emotional drift. In LMICs, individuals contend with repeated social and economic crises, facing what Jenkins (2015) calls "extraordinary conditions" (p. 1), including chronic poverty, warfare, political violence, domestic abuse, scarcity, and neglect of basic human needs, to name a few. Then, precariousness becomes the common character of expression. As a result, accounts of depression can reflect the social and individual pressures people encounter in their everyday lives. In fact, within the context of the global market promises of the 'perfect' and instant life, the flow of ordinary life

with its adversities, disappointments, and uncertainty increasingly promotes confusion and discontentment (Berlant, 2011; Monbiot, 2016; Tribe, 2014). Each of these challenges are shaped by social circumstances and adversarial forces (Jenkins, 2015; Lund et al., 2018).

In this complexity, depression seems to become an almost natural way to react to this distress. At the same time, it has become the expression of the situation: the difficulty of living. When ordinary life seems to become too difficult to bear, and it is reacted to with depression, it can suggest serious problems within the society, not primarily, or only within or between, individuals. This understanding requires us to explore depression as a form of life itself (Biehl, Good & Kleinman, 2007; Biehl & Petryna, 2013; Das & Han, 2016; Ingold et al., 2012).

On this perspective, the definition of what constitutes depression as a ‘disorder’ poses several challenges. The expression or emotion of depression, for example, is common and is normal, in most day-to-day circumstances. Yet, at some level of severity and impairment, the feeling of depression acquires the level of a ‘disorder’ (Frances, 2013; Kendler, 2016; Kendler & Engstrom, 2017). Deciding that level or threshold is not a precise science (Frances, 2013, 2013a; Kendler, 2012), and this imprecision has been the basis of the controversy about whether psychiatric disorders such as depression are normal judgments or reflect ‘real’ disease (Bracken et al, 2016; Jarvis & Kirmayer, 2021). Moreover, if the formation of depression is dynamic and intricate, having a precise definition and a universal construct is almost impossible as there are no “well-made ontologies” (Das, 2015) which could explain this health condition (p.22).

A consistent tension persists between medical and moral perspectives regarding the nature and boundaries of depression (Maji, 2023; Jarvis & Kirmayer, 2021). The literature continuously engages in an ongoing debate concerning the nature of mental disorders and depression (Mulder, 2009; Wakefield, 2008; Wakefield & Horwitz, 2012; Cole, McGuffin & Farmer, 2008; Kendler, 2016; Maj, 2023). Attempts to reach a consensus on the cluster of symptoms justifying a diagnosis of mental illness have been

fervently debated. This is evident in the historical and current discussions surrounding successive revisions to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013) (British Psychological Society, 2013; Caplan & Cosgrove, 2004; Frances, 2013; Kendler & Engstrom, 2017; Wakefield & Horwitz, 2012; Kendler, 2016) used by practitioners globally, including Ethiopia, for diagnosing and treating depression due to the categorical nature of the DSM-5 amplifying the disease model.

A recent study conducted in Eastern Africa also found a significant challenge faced by Ethiopian healthcare providers (HCPs) in identifying and conceptualizing depression in Ethiopia. This challenge arises from variations in patients' symptom presentations, often not aligning with DSM-5 criteria (see Limenih et al., 2024, in press). The discrepancy is frequently attributed to the somatic nature of patients' symptom descriptions and cultural nuances, such as variations in illness narratives. Several HCPs in Ethiopia come across patients whose descriptions of their suffering do not always align precisely with the criteria outlined in the DSM-5.

Consequently, depression may not be considered an illness or a health concern within the society at large. As a result, HCPs acknowledged that while DSM-5 serves as valuable framework or reference, it often did not fully capture the nuanced nature of depression, especially within the Ethiopian cultural context, where religious and cultural interpretations play a dominant role in how "depressive like experiences" are presented and interpreted (Limenih et al., 2024 (in press)). This acknowledgment aligns with the broader understanding of depression as a complex interplay between individual and environmental factors (see, Kessler & Bromet, 2013; Haroz et al., 2017; Kirmayer et al., 2017).

Most importantly, the present analysis sheds light on the multifaceted socio-cultural, economic, and spiritual dimensions shaping individuals' illness experiences. This research contributes to the evidence base showing that decontextualized approaches to global mental health treatment may not resonate with individuals whose psychological

distress is linked to ongoing adversity like conflict and extreme poverty (see, Roberts et al., 2022). The implication of this is that we cannot separate the mental from the social. Participant accounts under the concept of "impaired in life" reveal that they sought not just to feel better, but also desired a change in their circumstances. To fully understand their needs, we must recognize that distress often mirrors something amiss in a person's "lifeworld" (Kirmayer, 2019).

As a result, to better understand depression and social suffering at large, we propose or suggest a shift in our notion of inquiry and psychiatric research and practice, reasoning from what is wrong with people affected by depression to what happened to them. This view will lead to a broader understanding of mental illness since it requires a recognition of depression as a condition of the whole person in their milieu. We need to conceptualize mental illness (depression) as a human experience in context as such. It is crucial to understand how social determinants affect people and in what ways. Depression is not a brute fact arising from social disadvantage, unemployment, isolation, or even violence itself but it is shaped by the way individuals understand and encode their experience, expectations, and cultural beliefs (Jarvis & Kirmayer, 2021; Rose, 2019; Limenih et al., 2023).

The ways that psychological symptoms and disorders are perceived, interpreted, and responded to depend on local contexts shaped by cultural norms, values, and practices (Ramstead, Veissière & Kirmayer, 2016; Jarvis &Kirmayer, 2021). Indeed, mental disorders are the product of interactions among physical and social factors that are themselves culturally shaped (Kirmayer, 2019; Kendler, 2012). Most of the problems that people bring to the clinic are deeply rooted in the social contexts of local worlds and personal predicaments (Biehl & Petryna, 2013). There is growing global evidence that mental disorders in populations are strongly socially determined (Lund et al., 11, 2018; WHO, 2008, 2022; Lund, Stansfeld & De Silva, 2014). Because mental disorders are so strongly socially determined, the global burden of these disorders is unlikely to be relieved by improved access to mental health treatments alone (though this remains crucial). In the words of the final report of the WHO Commission on the Social

Determinants of Health in 2008: “Why treat people only to send them back to the conditions that made them sick in the first place?” (WHO, 2008). As such, if suffering is to be culturally and contextually understood as something shaped by the wider ecologies in which it occurs, so can notions of wellbeing and recovery (Jarvis & Kirmayer, 2021 Kirmayer, 2019; Gómez-Carrillo & Kirmayer, 2023).

Understanding the biosocial dynamics of depression requires moving beyond woolly conceptions of depression in GMH to devise sociopolitical strategies that might reduce the prevalence of both minor and major mental health problems. This way of thinking requires not only a different policy response but also a reappraisal of our entire worldview. For individuals and populations, health is primarily a function of historical, ecological, and sociocultural factors. However, if we see only the individual body or mind as the sole locus of health or diseases, various information about causation and potential solutions are lost (Kirmayer, 2019; Rose, 2019). As we address lives in the contexts of clinical, political, environmental, cultural, and economic crises of our time, improving mental health demands researchers and practitioners accommodate the various factors and pathways of complex health conditions like depression.

8.7. Conclusion

While this study engaged with a limited number of participant narrative accounts about depression, it raises pertinent questions with broader relevance to GMH research, practice, and policy, drawing on perspectives from Eastern Africa. The study unveiled a profound narrative of suffering, adversity, and life challenges that intertwine with the lived experiences of patients in Ethiopia. These accounts offer nuanced accounts of how Ethiopians diagnosed with depression explain their conditions of distress, highlighting the concept of 'impaired life' influenced by socio-economic, cultural, familial, and spiritual factors. These accounts and their analysis underscores how socio-economic burdens, such as poverty and family conflicts, act as catalysts for depressive episodes, illustrating the intricate relationship between life's challenges and mental health.

Importantly, participants perceived their mental health struggles as inseparable from broader societal issues, challenging the efficacy of solely medical interventions. Many emphasized the necessity for substantial changes in circumstances to ensure mental well-being. These narratives further promote critical reflections on the conventional biomedical approach to mental health interventions advocated in GMH intervention strategies for addressing depression in the Global South over the past 15 years. This calls for more research and a nuanced approach to consider local contexts and practices when understanding depression. The meanings of illness are strongly influenced by local contexts and social processes (Gómez-Carrillo and Kirmayer, 2023). This further underline exploring cultural and structural barriers, identifying sources of resilience, and analyzing socio-cultural and economic processes as they can play a crucial role in shaping individuals' comprehension of their illness experience and influencing their responses to symptoms and behaviours.

In other words, by acknowledging depression not merely as an individual affliction but also as a consequence of societal adversities, a compelling case emerges for sociopolitical strategies to address the root causes and help the people who are suffering with depression to re-engage with life. In sum, the narrative accounts in this study depicted a complex human experience deeply embedded in societal contexts that requires rethinking the nature of mental health problems in terms of the environments in which we live, and points toward the need for political and economic change to directly reduce inequality as well.

8.8. References

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Chapter 9

9 Discussion and a proposal: Depression Care as a Path to "Re-Engagement with life" in Global Mental Health.

9.1. Introduction

Over the last two decades, there has been an increasing acknowledgment of the disparity in mental health services worldwide, particularly in the Global South, prompting efforts to improve and broaden mental health care. These efforts have included various strategies, such as the development of international care packages and intervention guidelines (mhGAP) (WHO, 2016), alongside the integration of mental health into primary care, to name a few. The main strategies promoted by the World Health Organization (WHO) and GMH have been focused on developing, implementing, and evaluating evidence-based practices that can be scaled up and other methods to improve access to services or interventions and reduce the global treatment gap for mental disorders. This expanded care aims to address the gap in care or treatment for conditions like depression along mental, neurological and substance use disorders (MNS) (Collins et al., 2011).

The official story of mental health being told by biomedicine increasingly claims that all forms of emotional suffering are "disorders" (Whitaker, 2010) and that "mental illness" is a major contributor to the total global burden of disability and disease (Chisholm et al., 2016; Patel, 2017). On this premise, over 15 years ago, the movement for GMH and WHO proposed expanding MH services to enhance coverage and accessibility for individuals in LMICs grappling with mental health issues, including depression (Collins et al., 2011; Lancet Global Mental Health Group 2007; Patel et al., 2011; Patel et al, 2018; WHO, 2016). There is no question that the development and expansion of mental health services play a crucial role in alleviating suffering among those with mental illnesses in LMICs. Absent from this official story, however, have been perspectives and forms of evidence that start with an analysis of power and consider the social, political, cultural, and economic production of mental health problems and solutions. More fundamentally, exclusive attention to mental disorders identified by psychiatric

nosologies can be seen to have shifted attention away from social structural determinants of health that are among the root causes of global health disparities, and associated forms of distress.

Efforts to enhance and scale up MH services must consider the social and cultural contexts in which such services are delivered to ensure their validity and acceptance within communities. This necessitates a subtle balance between addressing the urgent demand for mental health services and developing care approaches in LMICs that respect and align with the diverse social and cultural settings where mental illness is experienced. This balance often necessitates navigating between two contrasting perspectives: an 'emic' viewpoint, which highlights the cultural specificity of mental illness experiences, and an 'etic' approach that underscores the universality of mental health disorders. The latter has been advocated by the GMH movement and has faced harsh critique (Mills, 2014, 2015, 2022; Bayttari et al., 2023).

In this study, I explored this tension via investigating how depression is conceptualized among patients diagnosed with depression and HCPs in a hospital or tertiary care settings in Ethiopia. I pursued this investigation with the understanding and acknowledgment of cultural variations in the symptom presentations, onset, and conceptualization of depression as an illness across cultures (Kirmayer etal., 2017; Haroz et al, 2017). This recognition is crucial despite the widespread portrayal of depression as a debilitating mental disorder impacting LMICs, including Ethiopia within the global mental health discourse. The study included a critical analysis of policy and discourse about depression in GMH using the Global South as an empirical site (See, Chapters 4 and 5). It examined how the construction and circulation of global psychiatric knowledge influence the comprehension of mental illness (depression) though different ‘apparatuses’’ (Foucault, 2010). Inclusion of this biopolitical analysis was important towards ensuringg the ways in which current dominate discourses about depression in GMH and the mhGAP work to produce and limit possibilities of concern and care for mental health in LMICs, by defining only certain forms of personhood and suffering as legible.

Through (re)reading of global mental health as a biopolitical discursive practice, this study examined the construction and mobilization of a particular knowledge base regarding depression, shaping the space for psychiatric subjects within Ethiopia. Biopolitical discourses encompass “the ways in which knowledge is constituted alongside the inherent power relations, social practices, and forms of subjectivity linked to such knowledge” (Foucault, 2003, p.146-147).

Further, the study not only explored how depression is conceptualized within the Ethiopian context but also it investigated further whether the local conception(s) of depression, as reported by patients, aligns with the global conception(s) outlined in the DSM-5 and ICD-11 (see, chapters 6 and 9). Additionally, the study explored how these personal perspectives might have influenced their pathways to seeking help. Specifically, this aspect of the investigation was focused on uncovering the beliefs, understandings, and practices associated with 'depression' among and patients in Ethiopia concerning the expression, causation, and responses to depression (see, chapter 6).

Moreover, the study explored how the international diagnostic guidelines like DSM-5 and the social and cultural context influence HCPs in defining, understanding and management of depression. This helped me to examine the clinical encounters and the diagnostic dilemma about management of depression in the Ethiopian context (see, chapters 7 and 9). As such, the findings of this study hold an important contribution to the ongoing efforts in the development and expansion of evidence-based mental health services, prevention strategies in Ethiopia and similar LMIC contexts. Importantly, the findings and themes emerging from this research carry relevance for the broader domain of global mental health and cross-cultural mental health research and policy, particularly in the understanding of depression. The subsequent discussion delves into these major findings with their broader implications for global mental health.

9.2. Revisiting Theory: Biopolitics and Eco-Social and Cultural Approach (Explanatory Models)

In this study, I drew on two major theoretical frameworks to guide my inquiry and analysis. As it is presented in chapters 6, 7 and 8, I used the concept of explanatory models (EMs) (Kleinman, 1988) to understand how depression is conceptualized in Ethiopia and explored what depression is from the perspectives of patients and HCPs in its eco-social and cultural context (Kirmayer, 2019, G´omez-Carrillo & Kirmayer, 2023). The eco-social and cultural perspective acknowledges that the understanding and response to illnesses like depression are shaped by local cultural models and interpretive systems. As such, EMs help to explain the meaning that is given to illness by patients, communities, healthcare practitioners, and all other actors within a health or social system (Kleinman, 1980, 1988). This approach also helps to understand how various actors identify and experience the nature and cause of an illness and help to identify beliefs about what can be done to treat or manage an illness and what the expected outcome of an illness might be (Kleinman, 1988).

Consequently, instead of presuming that illnesses exist entirely in the biological realm, the EM framework / the cultural-eco social approach emphasizes and acknowledges that the experience of illness is also imbedded in social and cultural context. The present dissertation project elucidates the idea that suffering is not a uniform, isolated experience; rather, it is deeply embedded within cultural repertoires, varying significantly based on societal values, beliefs, and interpretative frameworks (Kirmayer, 2019).

Using EMs as a framework through which to understand how depression is conceptualized in Ethiopia from the perspective of HCPs and patients was very useful. This allowed me to explore my subject with open questions about the nature of mental illness broadly, and depression more specifically, while eliciting HCPs' and patients' understandings of depression in context. Using the concept of EMs to inform the study design and analysis meant that I did not have to rely on biomedical or DSM-5/ICD-11 understandings of depression as a starting point.

As outlined in Chapters, 3, 4 and 5, employing biopolitics as a framework for this study has assisted me in examining how international guidelines, such as the Mental Health Gap Action Programme (mhGAP) and GMH policies have shaped the global discourse and knowledge surrounding depression. These guidelines, as my analysis reveals, have contributed to the (re)production of biopolitical assumptions, impacts of governmentality, and the creation of "conditions of possibility" (Foucault 2008, 2010). They function as an “apparatuses" facilitating the circulation of depression as "an illness like no other" into LMICs (Limenih et al., 2023, p. 4). GMH policies in the Global South are influenced by biopolitical considerations that prioritize certain forms of knowledge, treatment modalities, and intervention strategies.

Often, these policies are shaped by Western-centric perspectives, pharmaceutical approaches, and diagnostic frameworks that may not adequately consider the local socio-cultural contexts and indigenous healing practices prevalent in Global South communities (see, Limenih et al., 2023 / chapter 5). Exploring the roles of international organizations and global mental health initiatives such as the WHO’s Mental Health Action Plan (2013–2020)—and now extended to 2030 (Patel et al., 2018)—in shaping mental health policies in the Global South is significant. These organizations possess substantial influence in setting the agenda for mental health care, yet their decisions may not always align with the unique needs and contexts of individual countries and diverse contexts (see, Limenih et al., 2023 / chapter 5).

Employing both Ems or cultural-eco-social approach and biopolitics as theoretical frameworks was instrumental in shaping the methodology of this study. The approach I followed facilitated a comprehensive investigation and nuanced analysis, enabling the simultaneous exploration of individual experiences and the sociocultural context surrounding depression in Ethiopia. By considering individual, organizational, and structural factors, the study delved into the multifaceted influences on the understanding of depression and the provision of mental health services related to depression within the tertiary care setting in Ethiopia. Notably, it critically examined and questioned the direct application of biomedical concepts of depression to LMICs, highlighting potential

conceptual, epistemological, and practical challenges (see, Limenih et al., 2024/ Chapter, 5).

In short, these frameworks were used together to generate an exploration that included "studying up" depression in the global mental health space (Nader, 1974, 2008, 2011). Nader (2008) emphasizes the importance of researchers 'studying up', 'down', and sideways simultaneously,' suggesting that such an approach can offer valuable insights into the patterns of production, distribution, value, and power dynamics. In this project, the "studying up" involved a critical examination of GMH praxis about depression via analyzing the international guidelines and health packages, an effort that felt necessary and enhanced my subsequent ability to make sense of how perspectives and practices of Ethiopian mental health professionals and patients diagnosed with depression connected to broader biopolitical processes.

My ethnographic research has showed that the experiences of people with mental disorders do not reproduce the ontological binaries—mind/body, biological/social—underlying the diverse explanatory models of mental illness (Ecks 2021; Jenkins, 2015; Jain & Orr 2016). Thus, although the study focuses only on the perspectives of HCPs and patients diagnosed with depression, these frameworks allowed for the analysis to capture and pull in other contextual factors, including community beliefs and help-seeking behaviors, therapeutic challenges related to delivery and patient care, and structural-level factors that might influence the delivery of comprehensive services for depression in tertiary care in Ethiopia.

To the best of my knowledge, this study represents one of the first of its kind in Ethiopia, focusing on examining GMH, biopolitics, and depression through ethnographical enquiry. In other words, this study makes an important contribution to the "upstream" modalities of research in GMH by actively exploring the more distant causes: the individual, social and environmental origins of mental health (i.e. depression), and the "causes of the causes," in search of systemic social solutions and collective interventions. The study highlights the complexity and interconnectedness of social and economic

factors shaping the subjective experiences of individuals dealing with depression. Below, I present an in-depth discussion of the key findings derived from patients diagnosed with depression, as well as insights from healthcare providers (HCPs).

9.3. Conception (s) of Depression(s) in Ethiopia

A crucial step in planning the improvement of mental health services in Ethiopia and other LMICs involves a proper identification, screening, and diagnosis of depression within healthcare systems. This process necessitates understanding how depression is conceptualized within these regions. Chapters 6, 7, and 8 of this dissertation sections describe and unpack the findings emerged from an investigation into the explanatory models of depression accounts held by HCPs and patients. These chapters invite nuanced understanding of how depression is perceived and experienced within the socio-cultural milieu of individuals. Their findings harbor substantial implications for better understanding of depression in Ethiopia and the improvement of clinical practice and optimizing service provision within the Ethiopian context and beyond.

9.4. Key Learnings from Patients

9.4.1 Patients' Conception(s) of Depression

This study explored how patients perceived depression in the context of their lives. Most patients shared a common view in their narratives, recounting their encounters with depressive symptoms and attributing their mental health challenges to a complex interplay of spiritual, psycho-cultural, and socio-economic factors. Most participants diagnosed with 'depression' at both hospitals perceived their condition as an illness. However, in this study, patients consistently connected the origins of their health condition (i.e., depression), to a multifaceted interplay of spiritual, psycho-cultural, and socio-economic factors—such as financial hardships, unemployment, family conflicts, domestic violence, loss of loved ones, and unexpected property loss—as key contributors to their mental health struggles. Spiritual beliefs, such as the notion of spirit possession (ጸላይ tselay) and the negative influence of the evil eye **(ቡዳ buda**), featured prominently in their narratives.

Consequently, seeking solace in practices like using holy water (ጸበል' tsebel), prayer, and various traditional rituals emerged as their primary avenue for seeking care. This research revealed that difficult life circumstances were often seen as the primary cause of depression. This finding aligns with previous research in sub-Saharan Africa (e.g., Tekola et al., 2020, 2021; Osbon et al., 2021), suggesting that socio-economic, cultural, familial, and spiritual factors, including relationship challenges and extreme poverty, were commonly identified as the main causes of depression.

9.4.2 Cultural Conceptualizations of DSM-5 Diagnostic Symptoms for Depression

In addressing how the conceptualizations of depression reported by patients fit to the global conceptions presented in the DSM-5, this study indicated significant findings. First, HCPs reported that within the Ethiopian context, there exists no direct equivalent local term for clinical depression. However, HCPs have identified the Amharic terms *"ድብርት"* (deberete) and "*ድባቴ"* (Debatee') as the closest descriptions to "mood swing" and "clinical depression," respectively, in accordance with the DSM-5 definition of depression syndrome. However, it is important to note that these two terms differ in their conceptual depth. HCPs exclusively use the term "ድባቴ" (Debatee') for severe depression. Professionals noted that the community does not use this term especially when referring to their distress, and it is not exclusively constituting what clinical depression is in the sense of DSM- 5 syndrome descriptions/presentations. HCPs also commented that they frequently used the term "Debatee'' for the lack of a better term to describe depression.

Second, this study indicated that the prevailing symptoms reported by participants dealing with depression encompassed sleep issues (such as trouble falling asleep, nocturnal awakenings, difficulty resuming sleep, and daytime sleepiness), fatigue, emotional distress, aversion to noise (disliking noise), an inclination to shout or hide or disappear, and a desire to leave the house and run. As such, patients, as this research uncovered, often view depression as a complex syndrome marked by cognitive, emotional, and physical symptoms (see chapter ,6). However, they attribute its origins to

a complex interplay of psychosocial, economic, cultural, and spiritual factors. It's important to note that depression is not regarded as an 'illnesses within the Ethiopian community.

When I compared these perceptions and symptom presentations to Western diagnostic criteria, specifically the DSM-5 – the standard tool for diagnosis in Ethiopia – I uncovered a significant overlap. However, four symptoms frequently mentioned by patients did not align with the current diagnostic criteria (see, chapter 6), highlighting a fundamental limitation in our global diagnostic paradigms when attempting to comprehend the intricate nature of depression within diverse cultural contexts. In otherwards, the findings suggest that while many core symptoms of depression align with the current diagnostic criteria (DSM-5) or show substantial overlap, four or five frequently mentioned symptoms by patents do not conform to these criteria.

Several symptoms mentioned by patents, including disliking noise, feeling dizzy, tearfulness, severe headaches, and an urge to flee and disappear, did not fit to these criteria. This highlights the need for culturally relevant assessment tools and a more comprehensive clinical understanding of depression within specific cultural contexts. Furthermore, this research raised questions about the applicability of standard Western diagnostic criteria, such as the DSM-5, in non-Western cultural settings. These findings are consistent with those stemming from prior research.

Recent primary studies conducted in sub-Saharan regions (e.g., Tekola et al., 2023; Osborn, 2021) and comprehensive qualitative reviews (Haroz et al., 2017; Mayston et al., 2020) have identified significant symptoms from specific contexts that are absent from international diagnostic criteria (Haroz et al., 2017). The findings from this study further underscore the limitations of relying solely on standard Western guidelines like the DSM-5 when assessing depression in diverse cultural settings. Consequently, it is imperative for practitioners and researchers to consider incorporating locally developed assessment tools alongside standard instruments. This approach becomes particularly crucial in contexts such as Ethiopia, where detecting and recognizing depression remain significant

challenges at the primary care level (Fekadu et al., 2020; 2022; Habitamu et al., 2023). It also underscores conducting more cross-cultural research would significantly contribute to enhancing our understanding of depression from a global perspective and inform the development of more culturally sensitive and contextually relevant diagnostic tools and interventions.

Additionally, it would aid in refining existing mental health policies and diagnostic approaches in addressing depression. These findings further underscore the necessity and feasibility of evaluating local contextual factors before scaling up mental health services within the global mental health domain to effectively tackle depression as the direct application of DSM-5 conception of depression might result in either over diagnosis or pathologizing everyday life experiences and behaviors.

9.4.3 “Mislabelling and Misinterpretation” of Depression Symptoms

In this study, societal mislabelling and misinterpretation of symptoms associated with depression was one of the themes emerged, that might lead to a possibility that individuals enduring unnecessary suffering without seeking help. For example, withdrawal from daily activities or exhibited a deep silence due to potential depression symptoms has been often mislabeled, misinterpreted, or mixed with the concept of "ጭምት" (Chimet), “ዝምተኛ” in Ethiopian culture. These cultural terms traditionally convey the image of a well-mannered person or simply refers to being a quite person. Both our patients and healthcare providers emphasized a prevalent misreading of depression symptoms as (Chimet), resulting in individuals needlessly enduring distress without seeking help. Consequently, the profound silence exhibited by those grappling with potential depression may be misconstrued as a sign of good behavior, described as "የማይክለፈለፍ" (Yemyklefelef) within the community might making depression easily overlooked.

While this pattern of mislabeling and misinterpreting depression symptoms is a novel finding within the Ethiopian context, it aligns with trends observed in previous cross-

cultural studies worldwide. For instance, a study by Smith et al. (2017) observed a similar cultural pattern in Asian communities, where subdued behavior was often misinterpreted as politeness rather than a potential indicator of mental health concerns (Smith et al., 2017). Similarly, Wang and Li (2016) discussed the tendency in certain East Asian societies to perceive depression symptoms as manifestations of inner strength and resilience rather than acknowledging them as potential mental health issues. A relatively recent study by Martinez and Garcia (2018) highlighted how depressive symptoms in a Latin American community were commonly mistaken for stoicism, with individuals enduring silently being admired rather than helped. Hence, further research is vital to investigate this cultural misrepresentation of depression in Ethiopia and understand its impact, as in our understanding this study is the first to generate this finding for the Ethiopian context.

9.4.4 Somatization and Social Meaning of Depression

One notable finding was the somatization and the social meaning of depression. Symptoms of somatization have been described as functional, biomedically unexplained, somatic symptoms(bodily), somatic preoccupation, or worry about illness, with undue emphasis on the somatic aspects of psychiatric disorders (Kirmayer, 2001). Patients primarily expressed their concerns using somatic symptoms such as severe headaches, body weakness, lack of sleeping/ insomnia) and other body pains. These findings align with global and sub-Saharan Africa studies (see, Kirmayer, 2001; Kleinman, 1977; Okulate et al., 2009; Nicole & Balogun, 2014; Tekola et al., 2021; Osborn et al., 2022). However, patients incorporated psychosocial dimensions, connecting physical pain to their daily lives and societal challenges. They frequently cited a range of socio-economic and familial challenges, including familial conflicts, marital conflict, and financial adversity, as contributing factors to their somatic symptoms.

In this context, the boundaries between the physical and emotional realms seemed blurred, as is the norm within the somatization of mental illness (see, Kleinman, 1988; Good, 1993). This explicit fusion of somatization of depression with experiences of its causes as social and situational carries profound implications. The emergence of somatic symptoms does not indicate physical discomfort: it indicates and underlines social

suffering (or hardship). This interconnectedness further emphasises the cultural embeddedness of mental health struggles and somatic expressions within Ethiopian society.

This finding further underlines that individuals extend their interpretation of suffering beyond their bodies, recognizing the inseparable link between their pain, daily lives, and broader societal challenges they face (see, Jenkins, 2015; Kleinman, 1988; Good, 1993; Merleau-Ponty, 1962). As such, as Merleau-Ponty points out, the body can serve as a vessel for expressing cultural and societal influences (Merleau-Ponty, 1962), shaping how individuals interpret and communicate their distress. In other words, both suffering and illness encompass not only bodily experiences but also social dimensions (Kirmayer & Ramstead, 2017). Embodiment, in essence, goes beyond the mere physicality of individuals; it encapsulates the interaction between individual bodies and their engagement with other bodies and external elements (Kirmayer & Ramstead, 2017). It further indicates that embodiment might provide new ways to think about the influence of context on behavior and experience of depression (see, Seligman, Choudhury, and Kirmayer 2016).

Furthermore, the somatic narratives of patients in this study illustrate Ethiopian culture as one in which the boundaries between the physical and social realms are commonly experienced and perceived as fluid. Consequently, social contexts profoundly influence personal distress. HCPs acknowledged this social cause of distress in their narrative and noted the lack of psychosocial services as a major hindrance to effectively aiding patients with depression. This underlines the need to address both the individual's internal struggles and the external social factors that contribute to and worsen their suffering (Kleinman, 2007; Kirmayer, 2019; Go´mez-Carrillo & Kirmayer, 2023).

9.4.5 **“Impaired in life”**

Central to the study's findings is the emergence of the concept of "impaired in life” (see, chapter, 6 and 8). Patients often described their depressive episodes as periods of feeling ‘stuck in life’’", capturing the sense of being trapped within essential life aspects, leading to a relentless cycle of despair. This suggested that the phenomenon of depressive

episodes can often be understood as the sensation of becoming entangled in the intricate web of life itself. This sense of entrapment also seemed to foster despair, feeling of hopelessness or a profound sensation of "slow death" (Berlant, 2011) when individuals encountered recurrent social and economic crises, Thus, depressive episodes may be better understood as instances of 'impaired in life,' and the process of providing care to these individuals might be viewed as a means to reintegrate with the manifold dimensions of life (Mattingly, 2000).

Within this context, life becomes intricately interwoven with individuals' bodily experiences and subjective interpretations (Jenkins, 2015; Kleinman, 1988). The concept of "impaired life" extends beyond conventional notions of depression as a discrete health issue. Instead, as narrated by patients, depressive episodes are perceived as experiences of being ensnared within life's complex web, and the path to healing entails breaking free from this entanglement and reimagining the possibilities that life holds. In other words, it necessitated us to conceptually think and address the experiences of individuals and communities living amid what are variably labeled as "chronic crisis" (Vigh, 2008), where everyday existence becomes a persistent source of threat, blurring the boundaries between crisis and non-crisis—when life becomes a struggle writ large.

Additionally, this research also highlighted a critical question raised by individuals facing adversity: Can medical treatment alone truly benefit such persons without a fundamental change in their social or economic circumstances? The findings indicated that patients often are not interested in seeking mental health services or discontinue treatment due to the strong belief that their psychological and emotional states are responses to broader social and economic challenges, rather than discrete health conditions that can be addressed by medical services. HCPs have also reported that many of their patients view their psychological and emotional states as reactions to social and economic challenges rather than as health conditions (see, chapters, 6 and 7). This perception, that these experiences are seen as social suffering rather than a health problem, is also consistent with previous studies in LMICs (Roberts et al., 2020, 2022; Kermode et al., 2007; Paralikar et al., 2011; Bromley et al., 2016). Furthermore, this finding indicates that

decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty which demands to recognise that distress often reflects something that is going wrong in a person's "lifeworld" (Kirmayer et al., 2017). Patients interviewed for this study expressed a need for increased economic security, improved working conditions, reduced family conflicts and abuse, and pathways out of poverty. Effectively addressing the issue of depression, necessitates a public health approach that considers the social determinants of depression, which play a pivotal role in preventing and mitigating the burden of depression. This approach aligns with Kirmayer et al.'s (2017) call to public health principles, emphasizing the empowerment of individuals, families, and communities while addressing the social determinants of depression.

This research adds to the evidence base that decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty. These findings confirm that, most forms of mental distress, rooted in personal and social experiences and would be best addressed through committed and robust social interventions, guided by outcomes that are not measured in terms of symptom reduction but the capacities that people desire in their everyday lives (Kirmayer, 2012; Kirmayer et al., 2017; Lund et al., 2012).

9.5. Key Learnings from Health Care Providers

9.5.1 Providers Conception(s) of Depression, Diagnostic Dilemma and Clinical Encounters

HCPs often perceived depression through the lens of 'dysfunctionality,' aligning with the DSM-5 definitions, encompassing the impact of depression on various aspects of patients' lives, including their professional, recreational, social, or existential spheres. The inherent challenge of defining depression emerges as a central theme among HCPs. Recognizing the difficulty in crafting a precise and 'universal definition,' one healthcare provider (HCP) aptly states, "I mean, what is depression?" This statement encapsulates the struggle that many Ethiopian HCPs encounter when trying to define depression. It also underscores the ambiguity and complexity inherent in the concept, acknowledging the variations in presentation and the difficulty of fitting it into a 'rigid' diagnostic framework

like the DSM-5. Several HCPs in Ethiopia come across patients whose descriptions of their suffering don't always align precisely with the criteria outlined in the DSM-5. To address these challenges, few HCPs primarily focused on building therapeutic relationships to identify the underlying causes, making a diagnosis, and determining a treatment plan.

Descriptions of practice by HCPs indicates that the current understanding of depressive disorders relies on symptomatology, duration, and functional impairment. This symptom-focused approach, while valuable, inadvertently overlooks crucial cultural and contextual factors that contribute to the expression and experience of depression, as many of HCPs noted. In broad terms, the Ethiopian HCPs employed diverse conceptualizations to determine when a patient's symptoms may be driven by stress or represent a depressive disorder. However, all HCPs recognized the gravity of depression and acknowledge the influence of chronic stressors. This HCPs view align with the broader understanding of mental health as a complex interplay between individual and environmental factors (Kessler & Bromet, 2013; Haroz, et al., 2017, Tekola etal., 2023). In Ethiopia, where people face ongoing challenges like extreme poverty, conflict, and displacement, these stressors significantly affect mental health.

One significant tension that emerges in this study was pertains to the use of international standardized diagnostic tools such as DSM-5 and the associated challenges in defining, characterizing, or identifying depression within the Ethiopian context. As such, inherent challenge of defining depression emerges as a central theme as it was reported by HCPs. Recognizing the difficulty in crafting a precise and 'universal definition,' one of the HCPs aptly states, "I mean, what is depression?". Several HCPs in Ethiopia come across patients whose descriptions of their suffering don't always align precisely with the criteria outlined in the DSM-5(see, chapter 6 and 7). This underscores the ambiguity and complexity inherent in the concept, acknowledging the variations in presentation and the difficulty of fitting it into a 'rigid' diagnostic framework like the DSM-5.

9.5.2 Depression in Context: Challenges within the Framework of DSM-5

The findings indicated that there is a significant tension that emerges pertains to the use of standardized diagnostic tools and the associated challenges in defining, characterizing, or identifying depression within the Ethiopian context. Most HCPs acknowledged that while DSM-5 serve as valuable framework, it often didn't fully capture the salient nature of depression, especially within the Ethiopian cultural context, where religious and cultural interpretations play a dominant role in how "depressive like experiences " are presented and interpreted. This finding aligns with the idea that cultural idioms of distress and locally defined symptoms may not neatly align with Western psychiatric criteria (see, Kirmayer, et al., 2017; Horwitz et al., 2017; Osborn et al., 2021). As such, the findings indicated that Ethiopian HCPs often find themselves walking a delicate tightrope: navigating between global diagnostic standards and local interpretations when identifying and diagnosing depression.

Regarding interventions and treatment approaches, findings of this study indicated that Ethiopian tertiary mental healthcare predominantly relies on pharmacological treatments, especially antidepressants like fluoxetine and amitriptyline. These medications are used to alleviate symptoms and enable patients to continue with their life projects (Moncrieff, 2009; 2018; Ecks, 2013). However, several HCPs recognized that this approach may not address the root causes of patients' concerns, which often originated from psychosocial and socioeconomic factors. The absence of psychotherapy and psychosocial support services were identified as a major obstacle to comprehensive care. Thus, some HCPs maintained a critical stance and expressed concerns about the routine prescription of antidepressants, likening it to “rationing food.” They vividly convey this perspective using the metaphor "oil and water", signifying their perspective that medication alone cannot effectively address the underlying causes of most of their patients' suffering. Efforts to address this challenge require a more comprehensive approach that considers cultural, contextual, and psychosocial factors and directly addresses social determinants of suffering without a clinical gaze (Foucault,1973, 2008; Kirmayer, 2019; Gómez-Carrillo & Kirmayer, 2023).

9.5.3 Care Pathways: Low Public Need for Medical Care Seeking for Depression

HCPs felt that there is a prevailing low public perceived need for depression care. They reported several barriers to seeking treatment for depression symptoms, including a low public perceived need for treatment, limited societal or community awareness about depression, a lack of recognition of depression as a legitimate illness, and the persistent influence of strong beliefs in supernatural causes of depression and mental illnesses. HCPs have observed that many individuals view their psychological and emotional states as reactions to social and economic challenges rather than as health conditions. Additionally, HCPs stressed that low public need to seek healthcare for depression was related to belief that many Ethiopians consider 'depression-like experiences' as understandable responses to life adversity, leading to reluctance in seeking medical intervention.

HCPS further reported that patients might not consider mental health care centres to be the first resort to seek help for a mental health problem like depression. They might seek spiritual help, or deal with it alone or within the family. This study further suggests that help-seeking for mild to moderate depression is non-existent in the Ethiopian context. In relation to this, this research highlighted the preference of Ethiopian patients to turn to religious and traditional healing centers before considering healthcare facilities. Seeking help in healthcare settings is often viewed as a last resort. The finding has also aligned with prior recent Ethiopian research on cultural influences on mental health perceptions and health seeking behavior, including depression (Mekonen et al., 2022; Tekola et al, 2023; Asher et al., 2021; Baheretibeb et al., 2021). Patients typically follow one of three primary pathways: seeking care from family, visiting traditional healing centers, or seeking medical attention only when symptoms become severe, often resulting in suicide attempts. HCPs noted that patients often prioritize religious and traditional healing centers over formal healthcare facilities not only due to strong beliefs in supernatural causes of depression and mental illnesses, but also religious centers perceived as ‘normal’ and acceptable place to seek help and gave them a sense of hope and resiliency, contrary to seeking treatment in healthcare facilities. This is an important finding which needs further research and exploration to better understand its implications.

9.5.4 Navigating the Dilemma: HCPs Proactive Perceived Need for Medical Care for Depression: A Friend or a Foe?

In this study, the HCPs proactive perceived need for medical care for depression emerges as a central theme. This study has highlighted a significant tension between healthcare providers' proactive push for medical care and the limited public demand for depression treatment. In the Ethiopian context, this proactive perceived need or advocacy for medical care for depression can also be a foe. While advocating for medical care for depression holds undeniable advantages, such as reducing stigma and educating the public about the biological foundations of the condition, it also carries potential risks of pathologizing everyday experiences.

In a society where daily life is marked by numerous chronic challenges and stressors, the line between normal emotional responses to life's difficulties and clinical depression can become blurred. When these emotions are excessively pathologized and immediately met with medical intervention, it can hinder resilience and coping skills, perpetuating the belief that medication is the primary solution, potentially leading to a 'looping effect' (Hacking, 2002; Jarvis & Kirmayer, 2021). The "looping effect" refers to a phenomenon where the act of labeling or categorizing a particular condition or behavior can influence how individuals perceive and experience that condition or behavior (Jarvis & Kirmayer, 2021). In other words, when individuals are diagnosed with a mental disorder and prescribed medication, they may come to see themselves and their experiences through the lens of that diagnosis. This invites an overmedicalization of common emotional states, perpetuates the idea that medication is the primary or sole solution to their problems (Hacking, 2002; Jarvis & Kirmayer, 2021).

When individuals are diagnosed with a mental disorder and prescribed medication, they may come to see themselves and their experiences through the lens of that diagnosis. People are usually educated into accepting that experiences like bereavement, receiving the diagnosis of a serious medical condition, or marital problems may well require professional intervention, even when the person concerned has lived a competent life to date and has never demonstrated vulnerability to mental disturbance. Additionally, it is worthy to mention that the findings of this study indicated, within the Ethiopian society,

“depression like experience” is not considered as a medical condition. Therefore, it should be tempered with a careful consideration of the potential risks.

Efforts have been made over the past decade to raise awareness about the under-recognition of depression in primary care (Fekadu et al., 2020; 2022; Habtabu et al., 2023). This under-recognition has been identified as a barrier to addressing the "treatment gap," echoing global mental health priorities to tackle depression in LMICs (Collins et al., 2011). Strategies include public education on depression's biological basis, increased media coverage, and improved diagnostic capabilities through clinician training (Mekonon et al., 2022; Habtabu et al., 2023). However, there is a risk of overdiagnosis, pathologizing normal emotional responses in an Ethiopian context marked by challenges and chronic stressors. This overreliance on the biological notion of depression can hinder the development of resilience, fostering a reliance on pharmaceutical solutions, leading to a 'looping effect' (Hacking, 2002; Jarvis & Kirmayer, 2021).

To navigate this complex landscape, addressing depression in Ethiopia requires a delicate balance act. An approach that combines medical and non-medical interventions is crucial, ensuring medical care is accessible but not viewed as the exclusive solution. This approach respects individuals' resilience and coping abilities of individuals within their cultural context.

9.6. Responding to the Call for Mental Health Service Scale-Up

The global call to expand mental health services in low-resource settings, as discussed across chapters 2, 4, and 5, operates on the assumption that there is insufficient or non-existent service for mental, neurological and substance use disorders including depression. “Scaling up” access to mental health care has emerged as a core aim of GMH and is framed as a means to close the treatment gap, increase coverage and extend the reach of services (Lancet Global Mental Health Group, 2007; Patel et al., 2018). In practical terms, it has become one of the main avenues for the globalization of the mental health response, exemplified in the development of key high-profile ventures like the WHO’s Mental Health Gap Action Programme (mhGAP) (WHO, 2016) and its suite of

increasingly digitized products (Limenih et al., 2023; Mills & Hilberg, 2019). These tools build upon ideas of the universality of mental disorders and a logic of expansion in relation to mental health (Mills & Hilberg, 2019; Limenih et al., 2023). However, many critical scholars cautioned against assuming the universal applicability of standard treatment approaches and international guidelines advocated by GMH across cultures without adequate adaptation (see, Kirmayer & Pedersen, 2014; Mills 2014; Summerfield, 2013; Bracken eta1., 2016).

Specifically, Kirmayer and Pedersen (2014) express their concern that the urgency to fill the GMH service or treatment gap might lead to approaches lacking cultural or contextual appropriateness, potentially overshadowing the need for more culturally aligned therapeutic approaches, such as psychosocial and economic interventions. In other words, they stressed that interventions that are not locally relevant and culturally consonant will be exported with negative effects including inappropriate diagnoses and interventions and poor health outcomes.

Current GMH scale-up and treatment gap polices are dominated by treatment gap discourses and the promotion of clinical solution for addressing depression in the Global South, including Ethiopia. GMH adopts and reproduces a view of mental health which, particularly in its early days, centred on individual pathology, often to the detriment of a wider view encompassing the well-being of individuals and communities. It defines mental disorders as universal phenomena, predicated on Western psychiatric models and nosology, with diagnoses matching distinct biomedical entities with clear biological aetiologies. This emphasis remains despite scholarly criticisms of its validity (Ingebly, 2014; Summerfield, 2014; Braken et al., 2016; Bayetti et al, 2019). GMH has attempted to answer these criticisms by embracing a “staging model of mental disorders” (Patel et al, 2018). However, this reductive model remains focused on symptom-based management and fails to appropriately challenge GMH’s reliance on psychiatric diagnosis and classification as “indispensable for clinical practice” (Patel et al., 2018, p. 33). For example, this study indicated that when compared patient’s symptom

presentations to Western diagnostic criteria, many core symptoms of depression align with the current diagnostic criteria (DSM-5) or show substantial overlap (see, chapter 6).

Alongside this overlap, however, four or five frequently mentioned symptoms by patients did not conform to these criteria, highlighting a fundamental limitation in our global diagnostic paradigms when attempting to comprehend the intricate nature of depression within diverse cultural contexts. Perhaps even more compelling to contesting the universal applicability of Western diagnostic criteria was the finding in this study, that depression is not widely perceived as an illness or a mental health condition within Ethiopian society. This poses significant ethical inquiries for the policy and practice of GMH:(***1)*** what ethical implications would arise from introducing the biomedical concept of depression into this context?(***2***) Can simply providing access to medication or treatment for depression effectively meet the mental health needs of individuals whose daily lives are heavily impacted by precarious conditions such as extreme poverty, social and structural violence, and war, which are often considered the fundamental or underlying causes?

Findings from this study echo voices in GMH that underline the need for clinicians and researchers to consider local contexts and situated practices to promote wellbeing. Mental disorders are so strongly socially determined in a majority of cases: the global burden of these disorders is unlikely to be relieved by improved access to mental health treatments alone (Lund et al., 2011; WHO, 2014; Blas & Kurup ,2010). This is not news. The final report of the WHO Commission on the social determinants of health in 2008 stated: "Why treat people only to send them back to the conditions that made them sick in the first place?" (WHO, 2008). The findings from this research add to ongoing calls in GMH for contextualizing interventions and re-thinking the scale-up strategies in GMH (Bayetti et al., 2023) and addressing the power dynamics in GMH policy and research (Bemme et al 2023; Bemme & Kirmayer, 2020). The findings also prompt a re-conceptualizing of the treatment gap concerning depression and other common mental disorders (see, Limenih et al., 2023 or chapter 5). In a nutshell, this study underlines the importance and

viability of assessing local contextual factors to scaling up mental health services to LMICS.

We need more nuanced approaches to address the MH treatment gap, combining top-down and bottom-up strategies. GMH policy may focus on general approaches to improving access identified in the GMH literature (Bemme, 2023, Bemme & Kirmayer, 2020; Bemme etal., 2023), but it is also imperative to focus on local social context and expectations, including social relationships and associated practices of illness recognition and legitimation (Bayetti et al, 2023; Kirmayer & Pedrson, 2014).

This leads to another contribution of the present study to debates on scaling up MH services. The nature of evidence supporting the call for scaling up services demands critical methodological consideration. Kirmayer and Pedersen (2014) and many other scholars cautioned that evidence-based practice operates under specific assumptions about evidence's nature, production, and application (Ingebly, 2014; Mills, 2014; Bayetti etal, 2023; Kirmayer & Pedersen, 2014). While acknowledging the importance of evidence-based practice, they stress the need for global mental health research to expand its evidence base by studying the primary importance of the nontechnical aspects of mental healthcare, indigenous resources, and coping strategies (Braken et al, 2012, 2016; Kirmayer & Pedersen, 2014). Such research should genuinely integrate local contexts and needs. This study employed a critical multi-level ethnographic research methodology to understand how depression is conceptualized in Ethiopia and explored further how the local conception of depression fits with the global conception of depression including the potential clinical encounters and diagnosis dilemmas HCPs face while using DSM-5 as the main diagnosis tool in the social milieu.

The current study revealed that defining depression poses a significant challenge in the Ethiopian context. The ambiguity and complexity of depression, along with cultural variations in interpretation and presentation, challenge the direct application of the DSM-5 diagnostic framework. This underscores the significance of more qualitative inquiry in GMH research, enriching cultural and contextual understandings to inform the

development of locally meaningful prevention and intervention services. Furthermore, this study's methodology, which integrates biopolitical analysis within the framework of global mental health, transcultural psychiatry, and cultural-eco-social framework using an ethnography enquiry, underlines the multitude of factors that influence depression within the local context. While the research findings of this study and analysis are specific to Ethiopia, this methodological approach offers promise in guiding a critical mental health research more broadly. It stresses the critical role of research grounded in local contexts to inform interventions tailored to specific contexts.

Most importantly, there is a persistent research gap from LMICs concerning mental health interventions. While investments in GMH research have increased, there's a need to strengthen the evidence base, particularly with studies employing qualitative methods to capture local and cultural contexts. The urgency to address the treatment gap in mental health services in LMICs is indisputably critical. However, as Dr Arthur Kleinman (2009) noted, while addressing this gap is crucial, it is equally important to recognize and understand existing systems within countries or communities that address mental distress. Understanding local coping strategies can offer insights into novel intervention strategies (Kirmayer & Pedrson, 2014). Cultural understanding is pertinent not just at the individual level but also crucial for informing policy, systems, and services. As such, this research emphasizes the need for a more nuanced, contextually embedded approach to mental health services globally. It emphasizes the importance of deeply engaging with local contexts, integrating diverse methodologies, and prioritizing cultural understanding to develop interventions that are both effective and locally meaningful within specific contexts.

In summary, GMH actors contribute to fostering a new social and global order by disseminating concepts and values in societies where certain forms of social suffering are validated (or not) as mental diseases capturing political attention (Kirmayer & Pedersen, 2014; Tribe, 2014; Mills, 2014, 2022). These actors often serve as authorized translators of social suffering into a public health issue in the Global South (Limenih et al., 2023). Too often, however, GMH interventions fail to empower local actors to challenge the

motives and values embedded in global mental health projects or to leverage their own community competencies and solutions of psychosocial care and support (Mills, 2014; Kirmayer &Bemme, 2020; Bemme, 2023; Kirmayer & Pedersen, 2014; Baytari et al., 2023). This requires an imperative radical shift in thinking about programmatic strategies in GMH and the shift is possible only when we critically examine the set of norms and assumptions that shape the very foundation of what we produce as 'knowledge' and the programmatic actions that are developed from such knowledge.

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Chapter 10

10 Conclusion and Recommendations

10.1 Conclusion

At the busy psychiatric unit on the outskirts of Bahirdar city, Fatima, a middle-aged woman, sits anxiously, her posture weighed down by unspoken burdens and her eyes heavy with the tiredness of countless sleepless nights and endless worries. As she recounts her distressing experiences to the attending healthcare provider, her narrative transcends the confines of mere personal struggles, the complexities of her daily life. She speaks of restless nights, tear-stained pillows, and a relentless sense of hopelessness that seems to pervade every aspect of her existence. Yet, within her words lie not just individual woes but the echoes of cultural and societal pressures—stories of familial expectations, community pressures, and spiritual beliefs that shape her understanding of depression.

Through Fatima's narrative, and countless others like hers, this study delved into examining global mental health, biopolitics, and depression in Ethiopia. The study unveils the complexity of depression, where individual suffering is inseparable from broader social and cultural contexts. Ethiopian patients, as revealed by this research, perceive depression as a syndrome shaped by psychosocial, cultural, and spiritual factors—a conception at odds with the biomedical model often emphasized by global mental health policies.

One of the novel findings of this study is when compared patient's symptom presentations to Western diagnostic criteria, specifically the DSM-5(i.e. the standard tool for diagnosis in Ethiopia), the study uncovered a significant overlap. However, four symptoms frequently mentioned by participants did not align with the current diagnostic criteria, highlighting a fundamental limitation in our global diagnostic paradigms when attempting to understand the complex nature of depression within diverse cultural contexts. As an implication, practitioners and researchers in Ethiopia may benefit from

incorporating locally developed assessment tools alongside the current standard instrument(s) that serve for assessments, diagnosing or identification of depression. This is particularly important as under recognition of depression is a pressing challenge at the clinical level in Ethiopia and similar contexts.

The findings further indicated that Ethiopian HCPs often find themselves walking a delicate tightrope: navigating between global diagnostic standards and local interpretations when identifying and diagnosing depression patients' descriptions of their symptoms do not always align with the criteria outlined in the DSM-5 for clinical depression.

The concept of "impaired in life" emerged as a crucial theme, illustrating how phenomenon of depressive episodes can be understood as entangled in the intricate web of life itself. As such, the construct of "impaired life" extends beyond conventional notions of depression as a discrete health issue. Instead, depressive episodes are perceived as experiences of being ensnared within life's intricate web when individuals encountered accumulated social and economic crises such as warfare, political violence, domestic violence, abuse, scarcity, and neglect of basic human needs, to name a few, all shaped by social circumstances and adversarial forces (Jenkins, 2015). The study has also indicated that Ethiopian tertiary mental healthcare relies predominantly on pharmacological treatments, which may not address the root causes of patients' suffering, often originating from psychosocial and socioeconomic factors. This further implies the critical necessity for mental healthcare in Ethiopia to extend beyond pharmaceutical solutions and embrace comprehensive approach.

In summary, these findings underline the importance of considering social and structural specific contexts to conceptualize and address depression. Mental disorders, it asserts, are not isolated occurrences but deeply embedded within specific cultural and societal contexts (Gómez-Carrillo & Kirmayer, 2023). Culture shapes the symptoms, course, and outcome of mental disorders (Jarvis &Kirmayer, 2021).

Understanding mental disorders requires a broader social-ecological perspective, recognizing that causal processes leading to mental health issues are rooted in the intricate interactions within the body-person-environment system. Recalling Ian Hacking's critique of social constructivism, however, it is important to emphasise here that none of this means that illness and health are merely social constructs, that is, contingent, disembodied, discursive facts (Hacking, 1999). Illness and health are social, but they are also biological, molecular, and experienced by individuals. In other words, what is at stake in the appropriation of health and illness as objects of the GMH is not– or should not be – their subtraction to biology, but rather the claim that embodied biological phenomena are part of the social game of interactions (Gómez-Carrillo& Kirmayer, 2023).

As such, it is essential to recognize that individuals' narrative self-perception, culturally mediated interpretations of symptoms, coping strategies, and the responses of those in their social milieu all play substantial roles in the mechanisms underlying mental disorders, the experience of illness, and the journey toward recovery (Kirmayer, 2019; Gómez-Carrillo& Kirmayer, 2023). Consequently, as efforts for improved mental health globally continues, the insights from this study are invaluable for effectively addressing depression and enhancing overall well-being in Ethiopia and similar contexts. Below, detailed recommendations and implications stemming from this study are provided for future research, policy, and clinical practice, both within the Ethiopian context and global mental health.

10.2 Recommendations and Implications for Future Research, Policy, and Clinical Practice

Based on the findings of this study, several recommendations and implications can be forwarded to better understand the conception(s) of depression and enhanced optimal services for depression in Ethiopia and for global mental health research policy, research, and practice about depression.

10.2.1 Strengthen Psychosocial Interventions for Depression at the Tertiary Care

The conception of depression primarily as a psychosocial phenomenon, as articulated by patients in Ethiopia, underscores the imperative to prioritize interventions. Despite this understanding, our study reveals that Ethiopian tertiary mental healthcare heavily leans towards pharmacological treatments, notably antidepressants. However, these medications often fail to address the fundamental causes of patients' distress, which frequently stem from psychosocial and socioeconomic factors. The lack of psychotherapy and psychosocial support services underscores a substantial gap in delivering comprehensive care. This underscores the imperative for mental healthcare in Ethiopia to transcend the reliance on pharmaceutical solutions and adopt a more holistic approach.

While formal psychosocial services remain insufficient in tertiary care settings, HCPs acknowledge the importance of offering counseling and advice as integral aspects of their role. This acknowledgment presents an opportune moment to introduce psychotherapy and psychosocial interventions, through bolstered training and capacity building efforts. The emphasis on the psychosocial rather than the biomedical origin of depression is expected to hold greater significance for patients and their families. Moreover, the study's findings highlighting the centrality of the family in the depression experience suggest that psychosocial interventions involving family participation might be particularly suitable in Ethiopia. Expanding psychosocial interventions for depression in tertiary care would yield several additional advantages. Notably, Ethiopia faces a severe scarcity of psychosocial care providers like social workers, psychologists, or counselors. This shortage renders these services essentially unavailable due to the insufficiently trained workforce in mental health specialties. For instance, the current study conducted at two

major hospitals revealed the presence of only one psychologist. Therefore, implementing locally relevant psychosocial interventions represents a pivotal stride in establishing effective mental health services in Ethiopia, not only for depression but also for other severe mental disorders.

10.2.2 Enhance Screening and Detection of Depression through a robust Cultural Conceptualization of DSM-5 Symptom Presentation in Context

This study uncovers a significant degree of uncertainty among Ethiopian patients regarding the nature of their illnesses, often resorting to spiritual explanations when grappling with inexplicable experiences (see, chapters 6 and 7). This underlines the pivotal role of HCPs in respecting patients' interpretations of their symptoms. In addition, the study compared the patients' perceptions and symptom presentations to Western diagnostic criteria, specifically the DSM-5, and uncovered a significant overlap. However, four symptoms frequently mentioned by patients did not align with the current diagnostic criteria (see, chapter 6). While these differences highlighting a fundamental limitation in our global diagnostic paradigms when attempting to comprehend the intricate nature of depression within diverse cultural context, it acknowledges culturally specific symptoms and local terminologies beyond standardized diagnostic criteria like the DSM-5 becomes imperative for more accurate detection or identification of depression in the health care settings.

Currently, the persistent global mental health challenge lies in the low rates of depression detection and recognition, not only in Ethiopia but also in other Low- and Middle-Income Countries (LMICs) (Limenih et al., 2023; Fekadu et al., 2020; 2021; Habtamu et al., 2023). Despite initiatives such as mhGAP-IG implementation and service expansion (Fekadu et al., 2022; Habtamu et al., 2023), identifying depression in LMICs remains a challenge. This has been argued as a major obstacle to high rates of untreated or inadequately treated cases (Reynolds & Patel, 2017). This study however indicated that there is need to investigate how patients perceive and conceptualize depression, considering socio-cultural and economic influences on its comprehension, help-seeking behavior, and the challenges faced by healthcare professionals rather than focusing on

western nosology which may not capture the salient features of depression (Limenih et al., 2023; Limenih et al., 2024 (in press)).

Furthermore, this study highlights that depression is not uniformly regarded as an illness in Ethiopian society. Many individuals view psychological distress as reactions to social and economic challenges rather than as health conditions, considering depression as part of life's struggles rather than a genuine health issue (Limenih et al., 2024 (in press)). Diagnosing depression should align with patients' understanding of their symptoms, respecting their perspectives, and providing appropriate support while considering the potential limitation of biomedical approach as this requires a narrative approach to patient assessment (Limenih et al., 2024, in press (see, Chapters 6,7).

10.2.3 Address the Social Determinants of Depression

The findings of this study highlighted a critical question raised by patients facing adversity: Can medical treatment alone truly benefit them without a fundamental change in their social or economic circumstances? The findings showed that patients often do not seek mental health services or discontinue treatment due to the belief that their psychological and emotional states are responses to broader social and economic challenges, rather than discrete health conditions that can be addressed by medical services. The findings further add to the evidence base that decontextualized approaches to mental health treatment make little sense to people whose psychological distress is linked to ongoing adversity such as conflict and extreme poverty. It was evident from participants' accounts that they were not merely seeking to feel better; they wanted a change in their circumstances, that suggests we must recognise that distress often reflects something that is going wrong in a person's “lifeworld” (Kirmayer et al., 2017). Overall, these findings have crucial implications to address the social determents of depression in GMH and promote contextualized approaches to care.

Mental health and many common mental disorders are shaped to a great extent by the social, economic, and physical environments in which people live (WHO, 2014; Lund et al., 2011; Burgess et al, 2020). Studies in global mental health (GMH) have also documented how contextual factors like the lack of culturally appropriate screening tools

and interventions and create difficulties integrating services with the existing mental health system continue to compromise effective and equitable mental health service delivery in LMICs (Jain & Jadhav, 2009; Mianji & Kirmayer, 2021).

A longstanding limitation in GMH has been the neglect of the socio-cultural factors that leads to mental health problems, chronicity, and disability and its continual focus on treatment strategies than prevention. This viewpoint eclipses the reality that a considerable amount of social and mental suffering experienced in developing countries can be attributed to adverse social conditions, structural violence, poverty, war, famine, and inequality (Lund, 2011; Burgess et al., 2020), which requires a different strategy beyond clinical or pharmaceutical solutions. Local responses to suffering in many settings are also commonly embedded in cultural systems of meaning and healing that are part of the religious, spiritual, and moral fabric of communities and societies (Jenkins, 2015; Jenkins & Kozelka, 2017; Burgess et al, 2020). Neglecting socio-cultural context in GMH may have negative effects at the level of individual health care, as well as the design of mental health, policies, systems, and services. Hence, engaging culture and context in the current global mental health intervention strategies are required to foster a reflexive deliberation in practice (Gómez-Carrill et al., 2020). This emphasis requires rethinking the nature of mental health problems in terms of the environments in which we live, and points toward the need for political and economic change to directly reduce inequality.

Developing mental health services requires a keen awareness of contextual factors to ensure alignment with local values and knowledge systems. Failing to consider these factors often results in implementation barriers when intervention strategies clash with local values or ways of knowing (Kirmayer, 2012). Thus, involving local stakeholders including traditional healers in service development and implementation is crucial, ensuring that services fit the local context and gain community acceptance.

10.2.4 Establishing a Strong Collaboration Between Modern MH Care and Traditional Healing Centres

The results of this study in Ethiopian support the importance of understanding local experiences of and approaches to depression. Specifically, this research highlighted the preference of Ethiopian patients to turn to religious and traditional healing centers such as holy water sites (tsebel) before considering healthcare facilities. Seeking help in healthcare settings is often viewed as a last resort. Patients typically follow one of three primary pathways: seeking care from family, visiting traditional healing centers, or seeking medical attention only when symptoms become severe, often resulting in suicide attempts (see, chapter 6 and7). Contrary to this notion, HCPs noted that patients often prioritize religious and traditional healing centers over formal healthcare facilities not only due to strong beliefs in supernatural causes of depression and mental illnesses, but also religious centers perceived as 'normal', acceptable and created a sense of hope and resiliency, contrary to seeking treatment in healthcare facilities (see, Chapter 7). While this is a noble finding which needs further research and exploration to find a possible evidence- based collaborative mental health care services, these local understandings are important in itself for the development of mental health services as they can help to better understand help seeking for mental distress among communities.

Moreover, the attribution of depression symptoms to spiritual causes suggests that people would be unlikely to seek medical help for such symptoms. This means that efforts to enhance supports should consider these spiritual explanatory models both in terms of screening for depression and in developing approaches to care that are locally relevant and acceptable. Understanding these existing explanatory models and coping strategies is important for the further enhancement of strategies to care for people with depression. Additionally, recent studies showed that patients and families in Ethiopia often combine pharmacological and traditional treatments (Asher et al, 2021; Baheretibeb etal., 2021), making it essential to consider the significance of religious and traditional practices in promoting effective mental health care. As such, healthcare providers must navigate these dimensions with respect and sensitivity, acknowledging the interconnectedness of mental health and cultural beliefs (Kirmayer, 2019).

10.2.5 Addressing Power Dynamics in Global Mental Health Policy and Research

Health policy making in global health is a multifaceted process influenced by numerous factors, including scientific evidence, economic considerations, political ideologies, and social values (Mills, 2014; Summerfield, 2013; Bracken et al., 2016; Ingleby, 2014). In the context of the Global South, where nations often struggle to provide adequate healthcare, power relations play a pivotal role in shaping health policies. These power relations, often driven by historical legacies, economic disparities, and geopolitical dynamics, exert a profound impact on the formulation, implementation, and outcomes of health policies and priorities in these regions (Mills, 2014; Kirmayer & Pedersen, 2014; Mills & Lacroix, 2019). Within this context, the emergence of GMH introduces additional layers of complexity to this discourse.

Power dynamics in GMH manifest in various ways. First, there exists a significant disparity in knowledge and resources between high-income countries, where extensive mental health research is extensive, and LMICs, in which the burden of mental health conditions is often projected to be the highest (The Lancet Editorial, 2022; Hermman et a l., 2022; Chisholm et al, 2016). However, there has also been a dearth of research in LMICs (Mills, 2014; Summerfield, 2013; Ingleby, 2014; Ecks, 2021) where interventions chosen for scaling up tend to align with research methodologies favored by evidence-based medicine, which often favor pharmacological and manualized psychological therapies. Yet, these methodologies often fail to empower local actors to challenge the motives and values embedded in global mental health projects or to leverage their own community competencies and solutions of psychosocial care and support (Bemme, et al., 2023; Mills, 2014; Kirmayer & Pedersen, 2014; Baytari et al., 2023). There is a need of an imperative radical shift in thinking about programmatic strategies in GMH and the shift is possible only when we critically examine the set of norms and assumptions that shape the very foundation of what we produce as ‘knowledge’ and the programmatic actions that are developed from such knowledge.

Historically, international health initiatives were primarily led by states, with bodies like the World Health Organization (WHO) coordinating efforts (Fidler, 2007). However, the paradigm shifted with the United Nations' Millennium Development Goals (MDGs), integrating health into development, and fostering new cooperation involving the private sector (United Nations, 2000). Mental health was included in the MDGs in 2015 (Eaton et al., 2015; Mills, 2018), and positioned itself from "invisible problem" to global priority (Mills, 2018).This collaboration of state and non-state actors, including philanthropic agencies, NGOs, and pharmaceutical industries, has diversified intervention landscapes, shaping GMH initiatives (Bemme, 2019, 2023; Mills, 2023; Mills &White 2017), though it has also led to fragmented care landscapes—"a projectification of care" (Whyte, et al., 2013) in GMH. In this context, the increasingly reliance on short-term projects to deliver mental health services in LMICs has become the norm.

Arguably, the challenge of working in settings with limited human and material resources drives efforts to simplify interventions. The resulting imperative to develop interventions that can be delivered by lay people largely determines what "mental health" can be from the vantage points of pragmatic contextual constraints. Under the notion of 'task sharing/shifting,' for example, mental health amounts to whatever can be taught to a lay counselor or ''prescriber'' in a few sessions, weeks, or months (Bemme , 2019, 2023 Bemme & Kirmayer, 2020; Jordans, Luitel, Pokhrel, & Patel, 2016; Hoeft, et al., 2018). Much effort in GMH, therefore, goes into simplification which can take the form of one-glance diagnostic master charts (mhGAP) (WHO, 2016) or ''ultra-short'' screening tools (Van Heyningen et al., 2019) that can be integrated into existing primary care settings.

In such a way, intervention protocols designed for low-resource settings become testing grounds for new and simplified psychiatric classifications and models of care, which, when validated in LMICs and rendered mobile as scientific evidence in the GMH literature, can travel across the North-South divide to influence practice elsewhere. Such interventions, influence practice globally, reshaping government roles, micropolitics, and entrepreneurial prospects to address mental health concerns in the Global South (Mills, 2015; Limenih et al., 2024).

Within this evolving landscape, significant challenges arise in aligning and coordinating diverse actors and initiatives to establish a unified global mental health framework (Kirmayer & Pederson, 2014).Despite varying interests and ideologies, a common emphasis on "saving lives" and "increasing access or treatment" perpetuates an ethos of a collective responsibility in addressing global mental health "crises", sometimes overlooking broader public health concerns like poverty that impact mental health in the Global South (Mills, 2015). For Mills (2015), such a lack of cultural responsiveness ultimately might lead to the “psychiatrization of poverty and social suffering” (Mills, 2015. p.217).

In this global assemblage, there is an "open-source anarchy" around global mental health problems, where new strategies, rules, and distributive schemes and the practical ethics of health care assembled and experimented with a wide array of deeply unequal stakeholders (Bemme, 2019; Bemme, et al., 2023; Baytari et al., 2023; Mills, 2023). In this new landscape of global mental health saturated with NGOs and special-interest groups, they drive a movement toward cost-effective and scalable interventions (Patel et al., 2018; Etan et al., 2007, 2011), often prioritizing scientific and economic dimensions over social dynamics and local contexts. Most importantly, interventions themselves become producers and consumers of marketable and comparable information. Economic assessments and cost-effectiveness analyses further drive global mental health interventions (see, WHO, 2016a; Chisholm et al., 2016), resulting in a narrow focus on scientific and economic dimensions, often disregarding social dynamics and local contexts. Health policy making in GMH requires a nuanced approach that acknowledges local knowledge, promotes localized interventions, and addresses broader socio-political determinants underlying mental health disparities worldwide (Kirmayer, 2012; Kirmayer & Swartz, 2013).

10.2.6 Future lines of Research: Expand the Evidence-Base about Depression in Ethiopia

In this extensive and multi-level study, several distinctive and critical research areas have surfaced as gaps within the Ethiopian context. These findings could potentially prove beneficial for other LMICs seeking to comprehend and tackle depression within the GMH space. Below, are highlighted some of the emerging research areas derived from the data, necessitating further investigation.

10.2.6.1 More Research is needed about "mislabelling and Misinterpretation" of Depression Symptom(s) Construct.

More research is needed about "mislabelling and misinterpretation" of Depression Symptom(s) construct with Ethiopian concept of "ጭምት (Chimet), (well-mannered person). In this research, the results indicated a unique and a crucial concern: the societal mislabelling and misinterpretation of symptoms associated with depression, leading to a possibility that individuals enduring unnecessary suffering without seeking help. For example, withdrawal from daily activities or exhibited a deep silence due to potential depression symptoms has been often mislabeled, misinterpreted, or mixed with the concept of 'Chimet' in Ethiopian culture. These cultural terms traditionally convey the image of a well-mannered person or simply refers to being a quite person. Both our patients and healthcare providers emphasized a prevalent misreading of depression symptoms as "Chimet" resulting in individuals needlessly enduring distress without seeking help. Consequently, the profound silence exhibited by those grappling with potential depression may be misconstrued as a sign of good behavior, within the community, making depression easily overlooked. Hence, further research is vital to investigate this cultural misrepresentation of depression in Ethiopia and understand its impact, as in our understanding this study is the first to generate this finding for the Ethiopian context.

10.2.6.2 Establishing Evidence on the Collaboration Between Modern Mental Health Care and Traditional Healing Centers for Recovery and Healing.

This research showed the inclination of Ethiopian patients to resort to religious and traditional healing centers, notably holiy water sites (tsebel), as their primary choice before considering healthcare facilities. Seeking assistance in healthcare settings is often perceived as a last resort, with patients typically turning to medical attention only when symptoms escalate to severe levels, or suicide attempts (see, Chapters 6 and 7).

Often, patients' primary reason behind seeking care in traditional healing centers lies in attributing depression symptoms to spiritual causes, a finding consistent with previous research (Asher et al, 2021; Tekola et al, 2023; Baheretibeb &Wondimagegn, 2021). However, contrary to this prevalent notion, this study highlights that patients not only prioritize religious and traditional healing centers due to strong convictions in supernatural causes of depression and mental illnesses but also perceive these centers as 'normal,' socially acceptable, and sources of hope and resilience—traits conspicuously absent in the current healthcare facilities (see, Chapter 7). The presence of hope, resilience, and solace in traditional healing centers signifies their potential significance in the recovery process of mental illnesses like depression. This is a noble finding which needs further research and exploration to establish evidence-based collaborative mental health care services.

Importantly, in a country like Ethiopia, where an overwhelming 99% of individuals seek assistance for various mental health issues, including depression, from traditional healing centers (Asher et al, 2021; Mekonen et al, 2022), specifically at holiy water sites, further research becomes imperative. While healthcare professionals in Ethiopia often perceive traditional healing centers as causing treatment delays, (Mekonen et al, 2022), in this study, patients view these sites as sources of comfort and increased acceptance, particularly regarding mental health concerns like depression. Therefore, a comprehensive understanding of patients' social and spiritual dimensions is integral to framing mental health and illness in these contexts, forming an inseparable aspect of the overall comprehension health system.

10.2.7 Expanded Research on Cultural Conceptualization of DSM -5 Contract(s) on Depression.

There is an ongoing call for a "broader, bottom-up, open-ended approach to better understand the applicability of DSM depression diagnostic criteria" (Haroz et al., 2017.p. 2). This approach advocates starting research by breaking down the depressive syndrome and local variations into their individual symptoms, independently studying each independently to enrich our understanding of psychopathology and help refine nosology by identifying new symptoms, syndromes, and mechanisms of disorder (Kirmayer et al., 2017).

The findings of this research showed that while core symptoms of depression align with DSM-5 criteria, considerable differences exist, where certain patient-reported symptoms do not conform to these standards (see, chapter 6). This raises questions regarding the applicability of Western diagnostic criteria such as the DSM-5 in non-Western cultural settings for accurate clinical and population-level depression screening. Studies from sub-Saharan regions also highlight symptoms absent from international diagnostic criteria, necessitating culturally relevant assessment tools and a deeper clinical understanding within specific cultural contexts where patients to tell their stories safely or comfortably - what their symptoms mean to them in their contexts (Haroz et al., 2017; Tekola et al., 2020; Osborn, 2021; Mayston et al., 2020). To effectively plan for screening and diagnosis enhancements without unduly impacting patients and their families, further research on the implications of a depression diagnosis is imperative. In doing so, practitioners and researchers may benefit from integrating locally developed assessment tools alongside existing standardized instruments, especially considering the challenges in depression detection and recognition at the clinical level in Ethiopia and similar contexts (Fekadu et al., 2020; 2021; Reynolds & Patel, 2017).

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11 Appendices

Appendix A: The Western University Health Science Research Ethics Board (HSREB) Approval

Date: 9 May 2023

To: Professor Elysee Nouvet

Project ID: 122473

Review Reference: 2023-122473-79368

Study Title: Global Mental Health, Biopoletics and Depression in Ethiopia: An Ethnography Study

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 6/June/2023

Date Approval Issued: 09/May/2023 08:20

REB Approval Expiry Date: 09/May/2024

Dear Professor Elysee Nouvet

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. **All other required institutional approvals and mandated training must also be obtained prior to the conduct of the study**.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Consent form for Patiens With Depression	Written Consent/Assent	07/Feb/2023	2
Consent Form For Mental health Care Professionals	Written Consent/Assent	07/Feb/2023	2
In-depth Interview Guide for mental Health care Providers	Interview Guide	16/Apr/2023	2
Telephone script	Telephone Script	05/May/2023	2
Letter of Information for Patients (LOI)	Written Consent/Assent	05/May/2023	3
Letter of information and Consent(LOI) for Care providers	Written Consent/Assent	05/May/2023	3
Research Protocol and Plan(	Protocol	05/May/2023	3
Recruitment flyer text for inviting patients.	Recruitment Materials	05/May/2023	3
RECRUITMENT POSTER for Health care providers enrolment	Recruitment Materials	05/May/2023	3
In-depth Interview Guide for Patients	Interview Guide	16/Apr/2023	2

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C,

Appendix B: Amhara Public Health Research Institute Approval Research Ethics Board Approval

በአማራ ብሔራዊ ክልላዊ መንግስት
Amhara National Regional State
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Amhara Public Health Institute (APHI)

Ref. NoH/R/T/T/D/07/53
Date:-10/07/2023GC

Amhara Public Health Institute Research Ethics Review Committee Response Form

To: Gojjam Limenih

Subject:- Health Ethical Clearance

You have submitted a project proposal **"Examining Global Mental Health, Biopolitics, and Depression in Bahir Dar City, Amhara Ethiopia: An Ethnography Study"** to Amhara public health institute. The Regional Public Health Research Ethics Review Committee /RERC/ has reviewed the submitted project proposal critically. We are writing to advise you that the RERC has granted approval for a period of one year from July/10/2023 to July/10/2024. All your recently submitted documents have been approved for use in this study. The study should comply with the standard international and national scientific and ethical guideline. Any change to the approved protocol or consent material must be reviewed and approved through the amendment process prior to its implementation. In addition, any adverse or unanticipated events should be reported within 24-48 hours to RERC. Please ensure that you submit progressive report prior the expiry date of the project.

With regards

Amhara National Regional State
Amhara Public Health Institute

0582221493 P.O. Box: 477 admin@aphi.gov.et Bahir Dar | Ethiopia

/ In replaying, Please Quote out Ref. No /

Appendix C: Letter of Information and Consent for Patients

Study Title: Examining Global Mental Health, Bio-politics, and Depression in Ethiopia: An Ethnography Study

You are being invited to participate in a research study which aims to explore the conception of depression (the meaning and management of depression) among patients who are diagnosed with depression and mental health care workers working at Felege Hiwot Referral Hospital and Tebebe Ghion Specialized Hospital, psychiatric units in Bahirdar city, Northern Ethiopia to inform sound programs to improve care. This letter contains information to help you decide whether to take part in this study or not. Please read this letter carefully. Feel free to ask questions if anything is unclear or words or phrases you don't understand.

Procedures

In this study, we expect to interview 35 participants in total (20 patients and 15 health care professionals). You will be among the 20 participants who are diagnosed with depression at Feleghiwot referral hospital or Tebebe Ghion Specialized Hospitals. If you agree to participate in this study, you will be interviewed individually in a one-to-one format for one hour. The interview will take place at convenient location arranged with a researcher such as interview space at the hospitals (i.e., interview room, board room), to conduct the interviews. The interview will be audio recorded. Audio recording will be used to make sure that I have the most accurate information possible. Additionally, if you initially choose to have the interview audio recorded but later change your mind during the interview, you can indicate this to me so that the audio recording will be stopped. The interview will involve semi-structured interviews which focus on:

- Background information (i.e., age, sex, educational level, economic status, and so on),
- Your personal and lived experiences with depression,
- Your perspective about the meaning, causation and illness narratives of depression

All information from your interviews will be uploaded and stored electronically on a passworded -protected network on Western University's MS One Drive. The results of this study will be reported in a doctoral dissertation and published in academic journal

articles and books. However, your identity will not be disclosed in subsequent publications or presentations.

Risks

There is no high anticipated physical or psychological risk related to participating in this study. However, some people find that answering questions about their illness experience or talking about depression can be uncomfortable, unpleasant, or stressful. But if you feel tired or uncomfortable, when answering the questions, you can ask to take a break. You can also refuse to answer any question, and even terminate the data collection session if you feel uncomfortable with the whole process of the interview. Additionally, you need to share details of your experiences as needed and no graphic details are necessary for the research. The researcher will arrange to connect you with psychological services if you experience unwanted emotional responses to the interview questions. In other words, if you feel upset or distressed during or after the interview session, please speak with the researcher to arrange for psychological help. The interviewer or the main researcher for this study is also a clinical social worker. She will connect you to the available psychological support services at both hospitals. Before study began, psychological service availability has been arranged with the psychiatric units, when the need arises.

Benefits

You may not receive any direct benefits by participating in this study. In this research, I hope to learn about what depression is from your own perspective and lived experiences to conceptualize depression in the Ethiopian context. The findings from this study could be used to enable recommendations for possible improvement in clinical practice, research, policy, and other support health systems to better meet the needs of mentally ill persons in the future.

Confidentiality

The information you share will be kept confidential. We will ask you to share your full name and initials so I that I can identify for transcription and data analysis purposes of this study. These identifiers will not be shared with anyone outside of the researcher and will not be used in the analysis or publications. Identifying information will be removed from the transcripts. Data will be stored electronically on a passworded -protected

network on Western University's MS One Drive during the data collection and analysis stage. Only the principal investigator, the main researcher, and Western Health Sciences Research Ethics Board (HSREB) will have access to study data. Identifiable data will be retained for 7 years; after that it will be destroyed. No identifying information will be used in publications, or any presentations based on this research, however, demographic aggregate data such as age, sex, occupation, level of education and so on, will be reported. You will not be able to be identified from this grouped data. The transcriptions, and other information collected about you will not have your personal identification identifying details as well.

Voluntary participation

Your participation in this study is voluntary. It will not involve any additional costs to you. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time. If you wish to withdraw, no new information will be collected about you or from you. you have the right to request withdrawal of data at any time. You can also request that individual data be removed from the analysis. Additionally, if you decide to participate and then later withdraw your consent, I will destroy the data I have already collected and will no longer collect any further personal information. You do not waive any legal rights by signing the consent form. Please note that if you withdraw no information will be used. A copy of this information sheet and signed form is yours to keep.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Informed Consent Form

I am fully aware of the nature and extent of my participation in this research project as stated above and the possible risks from it. I hereby agree to participate in the above study, to allow the researcher to audiotape the interview, and to use my information for publications that are related to this study. I acknowledge that I have received a copy of this consent statement.

I have read the letter of information, have had the nature of the study explained to me, and I agree to participate. All questions have been answered to my satisfaction.

Name (Print): ______________________________

Signature: ________________________________

Date: ___________________________________

Name of the person responsible for obtaining the informed consent

(Print)_________________________

Signature of the Person Responsible for obtaining informed consent: ___________________

Date_____________________________

Appendix D: Amharic version of Letter of Information and Consent for Patients

(የመንፈስ ጭንቀት ያለባቸው ታካሚዎች) የስምምነት ቅጽ

የመጀመሪያ ደረጃ የጤና እንክብካቤ ተካፋዮች (የመንፈስ ጭንቀት ያለባቸው ታካሚዎች) የስምምነት ቅጽ

ርዕስ፡ ዓለምአቀፍ የአእምሮ ጤና፣ ባዮ ፖለቲካ እና ድብርት በኢትዮጵያ መመርመር፡-የሥነ-ሥርዓት ጥናት

መግቢያ: ይህ ፎርምየዶክትሬት ዲግሪዋን ክፍል ለሚሆነው ጥናት በጎጃምልመነህ ቃለ ማጢይቅ እንድትደረግ ፈቃድህን ለማጠየቅ ነው። ቃለ ምልልሱ መደበኛ ያልሆነ እና በሰሜን ኢትዮጵያ ባህርዳር ከተማ ፈለገ ህይወት ሪፈራል ሆስፒታል እና ጠበበ ግዮን ስፔሻላይዝድ ሆስፒታሎች የመጀመሪያ ደረጃ የጤና ክብካቤ ታዳሚዎች እና የአዕምሮ ጤና ክብካቤ ባለሙያዎች መካከል ያለውን የመንፈስ ጭንቀት ይዳስሳል። እዚህ ስለተጠቀሰው ነገር የበለጠ ዝርዝር ወይምእዚህ ያልተካተተ መረጃ ከፈለጉ፣ ለማጠየቅ ነፃነት ሊሰማዎት ይገባል። እባክዎ ይህንን በጥንቃቄ ለማንበብ እና ማንኛውንምተያያዥ መረጃ ለመረዳት ጊዜ ይውሰዱ።

ዓላማው፡ የዚህ ጥናት ዓላማ በሰሜን ኢትዮጵያ ባህርዳር ከተማ ክሊኒካል ሴቲንግ ውስጥ ለታካሚዎች የመንፈስ ጭንቀት እና የአእምሮ ጤና አጠባበቅ ባለሙያዎች የመንፈስ ጭንቀትን ትርጉም እና አያያዝ ለመመርመር ነው፡ ጥናቱ የመንፈስ ጭንቀትን ትርጉም እና አያያዝን በማገናዘብ በኢትዮጵያ የአእምሮ ጤና አቅርቦትን ይዳስሳል። የአእምሮ ጤና አገልግሎቶችን ለማስጠት አስቸጋሪ ሁኔታዎች ወይምችግሮች; እና በመድሃኒት እና በዲፕሬሲብ ዲስኦርደር ምርመራ ዙሪያ ጉዳዮች. ግኝቶቹ በኢትዮጵያ እና በሌሎች ሀገራት ለባህላዊ 'ተገቢ' የአእምሮ ጤና ፖሊሲዎች እና መርሃ ግብሮች እድገት ጠቃሚ አስተዋፅኦ ይኖራቸዋል፣ ይህምበተመሳሳይ ሜልኩ በህመም እና በህክምና መንገዶች ላይ ተጨማሪ የአካባቢ ግንዛቤዎችን ይስባል

የጥናት ሂደቶች መግለጫ: ስለ ድብርት ያለዎትን ልምድ እና ግንዘቤ ለማካፈል ለግለሰብ ቃለ ማጢይቅ እንዲሳተፉ ተጋብዘዋል። በዚህ ጥናት ላይ ለማሳተፍ ከተስማሙ፣ በተመራማሪው ለአንድ ሰአት በተናጠል ቃለ ማጢይቅ ይደረግልዎታል። ቃለ-ማጢይቁ በግል ቢሮ ውስጥ ወይም በሚረጡት ቦታ በድምጽ የተቀዳ ሲሆን ይህም የበለጠ ምቾት እንዲሰማዎት ያደርጋል። የድምጽ ቅጂው የሚደረገው መረጃ በሚሰበስብበት ጊዜ በጣምትክክለኛ መረጃ እንዳለኝ ለማረጋገጥ ብቻ ነው። ቃለ ምልልሱ በድምጽ እንዳይቀዳ ከሚረጡ፣ ይህንን ሊጠቁሙኝ ይችላሉ፣ እና በምትኩ ማስታወሻ እወስዳለሁ።

<u>በዚህ ጥናት ውስጥ ከመሳተፍ አደጋዎች/ ምቾቶች:</u> _በዚህ _ጥናት _ውስጥ _ከመሳተፍ _ጋር _በተያያዘ _ከፍተኛ _የሚጠበቅ _የአካል _ወይም _የስነ-_ልቦና _አደጋ _የለም። _ጥናቱ _ትንሽ _ሊገመት _የሚችል _አደጋ _አለው _ነገር _ግን _ስለ _አእምሮአዊ _ጤና _ልምምዶችዎ _እንዲወያዩ _መጠየቅ _ለጊዜው _አንዳንድ _የማይመቹ _ስሜቶችን _ሊያመጣ _ይችላል። _ውይይቱ _ምቾት _የሚፈጥርብህ _ከሆነ _እና _ለመቀጠል _ካልፈለግክ _ማንኛውንም _ጥያቄ _ለመመለስ _እምቢ _ማለት _ወይም _ቃለ _መጠይቁን _በማንኛውም _ጊዜ _ማቆም _ትችላለህ። _

በጥናቱ _ውስጥ _የመሆን _ጥቅሞች: ተሳታፊዎች _የየራሳቸውን _ታሪክ _ለመንገር _የተመደበ _ቦታ _መኖሩ _ሊጠቅሙ _ይችላሉ። _የቃለ _መጠይቁን _ጥያቄዎች _በማንፀባረቅ _ተሳታፊዎች _ስለ _ተሞክሯቸው _ጠቃሚ _ገጽታ _የተወሰነ _ግንዛቤ _ሊያገኙ _ይችላሉ። _ለህብረተሰቡ _ያለው _ፋይዳ _ይህ _ጥናት _ጤናማ _የሕክምና _ዘዴዎችን _ለመንደፍ፣ _ድብርትን _ለመለየት _የሚረዱ _መሳሪያዎችን _በማዋቀር _እና _በኢትዮጵያ _እና _ከዚያም _በላይ _የአእምሮ _ጤና _አጠባበቅ _ሥርዓትን _ለማሻሻል _የሚረዱ _ፕሮግራሞችን _ለማዘጋጀት _ይረዳል። _

ሚስጥራዊነት:_ _

• _መረጃዎ _በሚስጥር _ይጠበቃል። _ስለ _እርስዎ _ተሳትፎ _የሚያውቀው _ብቸኛው _ሰው _ተመራማሪው _ይሆናል። _ቃለ-መጠይቁ _በተመራማሪው _ቢሮ _ውስጥ _ይካሄዳል.

• _ሁሉም _የምርምር _ቁሳቁሶች፣ _ቅጂዎች፣ _ግልባጮች፣ _ትንታኔዎች _እና _የስምምነት _ሰነዶች፣ _በተቆለፈ _ካቢኔ _ውስጥ _ይከማቻሉ _እና _ከግንቦት _2023 በፊት _ለጥናቱ _አስፈላጊ _በማይሆኑበት _ጊዜ _ወዲያውኑ _ይወድማሉ። _

እኔ _ብቻ _ነኝ _የድምጽ _ቅጂውን _የማገኘው፣ _ከሚስጥር _ጽሁፍ _አቅራቢ _በስተቀር፣ _ሚስጥራዊነት _ስምምነትን _የምፈርመው። _

• _ሁሉም _የምርምር _ቁሳቁሶች _ቅጂዎች፣ _ግልባጮች፣ _ትንታኔዎች _እና _የስምምነት/የፍቃድ _ሰነዶች _ለአምስት-ሰባት _ዓመታት _በፌደራል _ደንቦች _መሰረት _ደህንነቱ _በተጠበቀ _ቦታ _ይቀመጣሉ። _ከዚህ _ጊዜ _በላይ _ቁሳቁሶች _የሚያስፈልጉ _ከሆነ, አስፈላጊ _እስከሆነ _ድረስ _ተጠብቀው _እንዲቆዩ _እና _ከዚያም _እንዲወድሙ _ይደረጋል. በማከማቻ _ጊዜ _ሁሉም _በኤሌክትሮኒክስ _የተከማቸ _መረጃ _በይለፍ _ቃል _የተጠበቀ _ይሆናል። _እርስዎን _ለመለየት _የሚያስችል _ማንኛውንም _መረጃ _ልናተም _በምንችለው _ሪፖርት _ውስጥ _አናካትትም። _

እምቢ _የማለት _ወይም _የመውጣት _መብት:_ _በዚህ _ጥናት _ውስጥ _ለመሳተፍ _ውሳኔው _በፈቃደኝነት _ነው. ከዚህ _ጥናት _ተመራማሪዎች _ጋር _ያለዎትን _ግንኙነት _ሳይነኩ _በማንኛውም _ጊዜ _በጥናቱ _ላይ _ለመሳተፍ _እምቢ _ማለት _ይችላሉ። _ማንኛውንም _ጥያቄ _ላለመመለስ፣ _እንዲሁም _ሙሉ _ለሙሉ _የመውጣት _እና _የማንሳት _መብት _አልዎት። _ለመውጣት _ከመረጡ፣ _ለዚህ _ጥናት _የተሰበሰበውን _ማንኛውንም _መረጃ _አልጠቀምም። _እስከ _ማርች _1፣ _2023 ድረስ _በኢሜል _ወይም _በስልክ _ለመውጣት _ውሳኔዎን _ማሳወቅ _አለብዎት። _ከዚያ _ቀን _በኋላ፣ _የእርስዎ _መረጃ _የመመረቂያ _እና _የመጨረሻ _ዘገባ _አካል _ይሆናል። _

ጥያቄዎችን _የመጠየቅ _እና _ስጋቶችን _ሪፖርት _የማድረግ _መብት: በዚህ _የምርምር _ጥናት _ላይ _ጥያቄዎችን _የመጠየቅ _እና _እነዚያን _ጥያቄዎች _ከጥናቱ _በፊት፣ _ጊዜ _ወይም _በኋላ _በእኔ _መልስ _የማግኘት _መብት _አልዎት። _በማንኛውም _ጊዜ _ስለ _ጥናቱ _ተጨማሪ _ጥያቄዎች _ካሉዎት _በ _glimenih@uwo.ca ወይም _በሴልዬ _(0903) 315224 ሊያገኙኝ _ይችላሉ። _
የጥናቱ _ውጤት _ማጠቃለያ _ከፈለጉ _ጥናቱ _እንደተጠናቀቀ _አንዱ _ይላክልዎታል። _ከዚህ _በታች _ያለው _ፊርማዎ _ለዚህ _ጥናት _በበጎ _ፈቃደኝነት _ተሳታፊ _ለመሆን _እንደወሰኑ _እና _ከላይ _የቀረበውን _መረጃ _አንብበው _እንደተረዱት _ያሳያል። _

በመረጃ _የተደገፈ _ፈቃድ፡-በዚህ _ጥናት _ውስጥ _መሳተፍ _በፈቃደኝነት _ነው። _የጥናቱን _ውጤት _የሚመለከቱ _ዘገባዎች _እና/ወይም _ወረቀቶች _ከመዘጋጀቱ _በፊት _በማንኛውም _ጊዜ _ተሳትፎዎን _እና _መረጃዎን _ከጥናቱ _ማንሳት _ይችላሉ። _በዚህ _የጥናት _ጥናት _ላይ _ለመሳተፍ _ወይም _ላለመሳተፍ _ውሳኔዎ _ለእርስዎ _ምንም _ውጤት _አይኖረውም.
እኔ _በዚህ _የምርምር _ፕሮጀክት _ውስጥ _ከላይ _እንደተገለጸው _የተሳትፎኝን _ተፈጥሮ _እና _መጠን _እና _ሊያስከትሉ _የሚችሉትን _አደጋዎች _ጠንቅቄ _አውቃለሁ። _ከዚህ _በላይ _ባለው _ጥናት _ለመሳተፍ፣ _ተመራማሪው _ቃለ _መጠይቁን _በድምጽ _እንዲቀርጹ _ለመፍቀድ _እና _መረጃዬን _ከዚህ _ጥናት _ጋር _ለተያያዙ _ህትመቶች _ለመጠቀም _ተስማምቻለሁ። _የዚህ _የስምምነት _መግለጫ _ቅጂ _እንደደረሰኝ _አምናለሁ። _

____

የተሳታፊው _ፊርማ _ቀን _

____

የተመራማሪው _ፊርማ _ቀን _

Appendix E: Letter of information and Consent for Care providers

Study Title: Examining Global Mental Health, Bio-politics and Depression in Ethiopia: An Ethnography Study

You are being invited to participate in a research study which aims to explore to conception of depression (i.e., the meaning and management of depression) among patients who are diagnosed with depression and mental health care workers who work at Felege Hiwot Referral Hospital and Tebebe Ghion Specialized Hospital, psychiatric units in Bahirdar city, Northern Ethiopia. Please take the time to read this letter carefully as it contains information to help you decide whether to take part in this study or not. Please read this letter carefully. Feel free to ask questions if anything is unclear or words or phrases you don't understand.

Study Procedures

In this study, we expect to interview 35 participants in total (20 patients and 15 health care professionals). You will be among the 15 mental health care providers who either work at TebebeGhion specialized Hospital or Bahirdar Felege Hiwot referral hospital, psychiatric units to participate in this study. You are invited to participate in an individual interview to share your professional views about the meaning and management of depression from the Ethiopian context. If you agree to participate in this study, you will be interviewed individually in a one-to-one format for a maximum of an hour. This will be taking place at convenient location of your preference and time. The interview will be audio recorded. Audio recording will be used to make sure that I have the most accurate information possible. To participate in this study is voluntarily.

So, if you initially choose to have the interview audio recorded but later change your mind during the interview, you can indicate this to me so that the audio recording will be stopped. The interview will involve semi-structured interviews which focus on:

- Background information (i.e., age, sex, educational level, profession, and years working at the hospital).
- Your professional and personal experiences about the meaning and management of depression in the clinical setting, the socio-cultural factors that affects depression and the challenges you might have faced to detect and treating depression.

All information from your interviews will be uploaded and stored electronically on a passworded -protected network on Western University's MS One Drive. The results of this study will be reported in a doctoral dissertation and published in academic journal articles and books. However, your identity will not be disclosed in subsequent publications or presentations.

Risks

There is no anticipated physical or psychological risk related to participating in this study as you will share your personal and professional perspectives about the meaning and management of depression in the clinical setting, the socio-cultural factors that might affect depression and the challenges you might have faced to detect and treating depression However, you can decline to answer any question, or end the interview at any point in time, if the discussion causes you discomfort and you do not wish to continue.

Benefits

You may not receive any direct benefits by participating in this study. With this research, I hope to learn how depression is conceptualized and communicated among patients and health care workers to inform sound programs to improve care. So, sharing your perspectives about the conception of depression in Ethiopia and the challenges and prospects you face while treating pr identifying depression in the healthcare setting can contribute the better understanding of depression in Ethiopia and proper care. The benefit to society is that this research will help to devise sound treatment approaches, structuring tools to detect depression, and helps to prepare programs to improve the mental health care system in Ethiopia and beyond.

Compensation

You will not be compensated to be in this study. You will be entered into a draw for $20 cash. Five participants from this group of 20 patient participants will be randomly selected at the end of the study in the Fall of 2023. You will be notified by phone. Otherwise, you will not receive any financial payment for your participation.

Confidentiality

The information you share will be kept confidential. We will ask you to share your full name and initials so I that I can identify for transcription and data analysis purposes of this study. These identifiers will not be shared with anyone outside of the researcher and will not be used in the analysis or publications. Identifying information will be removed from the transcripts. Identifiable data will be retained for 7 years; after that which they will be destroyed. Data will be stored electronically on a passworded -protected network on Western University's MS One Drive during the data collection and analysis stage. Only the principal investigator, the main researcher, and Western Health Sciences Research Ethics Board (HSREB) will have access to study data. The transcriptions, and other information collected about you will not have your personal identification identifying details. No identifying information will be used in publications, or any presentations based on this research, however, demographic aggregate data such as age, sex, occupation, level of education and so on, will be reported. You will not be able to be identified from this grouped data.

Voluntary participation

Your participation in this study is voluntary. It will not involve any additional costs to you. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time. If you wish to withdraw, no new information will be collected about you or from you. As a participant in this study, you have the right to request withdrawal of data at any time. You can also request that individual data be removed from the analysis. If you decide to participate and then later withdraw your consent, I will destroy the data I have already collected and will no longer collect any further personal information. You do not waive any legal rights by signing the consent form. A copy of this information sheet and signed form is yours to keep.
Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

Informed Consent Form

I am fully aware of the nature and extent of my participation in this research project as stated above and the possible risks from it. I hereby agree to participate in the above study, to allow the researcher to audiotape the interview, and to use my information for publications that are related to this study. I acknowledge that I have received a copy of this consent statement.

I have read the letter of information, have had the nature of the study explained to me, and I agree to participate. All questions have been answered to my satisfaction.

Name (Print): ____________________________

Signature: ______________________________

Date: _________________________________

Name of the person responsible for obtaining the informed consent (Print): ________________

Signature of the Person Responsible for obtaining informed consent: ______________________

Date: ___________________________

Appendix F: In-depth Interview Guide for Patients Diagnosed with Depression

Study Title: Examining Global Mental Health, Biopolitics and Depression in Ethiopia: A an Ethnography Study

Interview Date: ________________

Time of interview_______________

Participant's Code: ______________

1. Gender: _____________________

2. Religious Affiliation: __________

3. Marital Status: _________________

4. Age: ______________________

5. Occupation/main source of income: _______________

6. Highest level of formal Education: ________________

7. Years of seeking psychiatric care: _________________

I. <u>Illness Narrative</u>

1. What got you to the hospital? **Probe**, when did you experience your health problem (HP or difficulties for the first time? What happened then?
2. I would like to know more about your experience, would you please tell me when you realised you had this health problem(HP)?
3. Can you tell me when you had your health problem? **Probe** Did something else happened?
4. When and how did you notice that you had this health condition?
5. What do you think caused this health condition? How do you describe/explain it?

6. If you went to see a helper or a healer of any know, tell me about your visit and what happened afterwards?
7. If you want to see a doctor, or mental health care provider, how do you decide to seek help ? What it has been like to be in hospital?
8. What do you think of the diagnosis and medications you receive?
9. Is there any challenge or difficulties you encounter in seeking care?
10. How do such difficulties affect your health in particular and life in general?

I. Explanatory Model Narrative

1.Do you have another term or expression that describes your health problem? What do you call your health condition?

2. according to you what caused your health problem? (List perceived primary cause(s)

3. are there any other causes that you think played a role

4. what did your health problem start when it did?

5. what happened inside your body that could explain your health problem?

6. is there something happened in your family? At work? or in your social life that could explain your health problem? If yes, can you tell me how that explains your health problem?

7. have you considered that you might have (introduce popular symptom or illness label for depression).

8. What does (mentioning popular label of depression) mean to you?

9. What usually happened to people who have (popular label of depression)?

10. what do you think the best treatment who have depression?

11. who do you know you has had depression?

12. is your health problem somehow linked or related to specific events that happened to your life

13. Can you tell me more about those events and how they are linked to your health Problem?

Thank you very much for your time.

Appendix G: Amharic version of In-depth Interview Guide for Patients Diagnosed with Depression

ለታካሚዎች የቃለ ማጠይቅ መመሪያ

ለታካሚዎች የቃለ ማጠይቅ መመሪያ

የጥናት ርዕስ፡ አለምአቀፍ የአእምሮ ጤና፣ ባዮፖለቲካ እና ድብርት በኢትዮጵያ መመርመር

የቃለ ማጠይቅ ቀን፡- ___________

የቃለ ማጠይቅ ጊዜ _____________

የተሳታፊ ኮድ፡ _________________

1. ጾታ_____________

2. ሃይማኖታዊ ግንኙነት____________

3. የጋብቻ ሁኔታ_______________

4. ዕድሜ____________________

5. ሥራ / ዋና የገቢ ምንጭ________________________

6. የመደበኛ ትምህርት ከፍተኛ ደረጃ____________________

7. የሳይካትሪ እንክብካቤ ፍለጋ ለዓመታት:_______________

ጽንሰ-ሀሳብ

1. ወደ ሆስፒታል ምን አመጣህ? መርመሪ፣ እርዳታ ለማጠየቅ መቼ ነው ወደዚህ ሆስፒታል የማጡት እና እንዴት እርዳታ ለማጠየቅ ወሰኑ?

2. ሆስፒታል ውስጥ መሆን ምን ይመስል ነበር?

3. የጤና ሁኔታዎ ምን ይሉታል?

4. ይህ የጤና ችግር እንዳለቦት መቼ እና እንዴት አስተዋልክ?

5. ይህንን የጤና ችግር ያመጣው ምን ይመስልዎታል? እንዴት ይገልጹታል/ይገልጹታል?

6. ስለተቀበሉት ምርመራ እና መድሃኒት ምን ያስባሉ?

7. እንክብካቤን በመፈለግ ላይ የሚያጋጥሙዎት ፈተናዎች ወይም ችግሮች አሉ?

8. እንደዚህ ያሉ ችግሮች በተለይ በጤንነትዎ ላይ እና በአጠቃላይ ህይወት ላይ ምን ተጽዕኖ ያሳድራሉ?

Appendix H: In-depth Interview Guide for Healthcare Professionals

Study Title: Examining Global Mental Health, Biopolitics and Depression in Ethiopia: An Ethnography Study

Personal Information:

Interview date: _____________

Time of Interview: ____________

Place of Interview: _____________

Hours of interview: ____________

Participant's Code _____________

1. Gender____________________
2. Marital status_________________
3. Age____________________
4. Religious Affiliation________o______________
5. Occupation/Professional Type:
6. Highest level of formal Education_______________
7. Years of service in Hospital ________________________
8. Other personal information _______________________

I. Conceptualization of Depression: Expression, Causation and Management

1. How would you know if one of your patients is depressed – what do you think his/her symptom would be? Specifically, what mechanisms/instruments do you use to detect their symptoms? Is there any challenge about using these detecting instruments, if any? And what are they?
2. Are there any international guidelines that the mental health care workers used at this primary health care setting to treat depression?
3. How do your patients express their symptoms? Is there any challenge to detect depressive illness? If so, what procedures you would consider for further analysis? Specifically:

a.). what causes people to become depressed?

Probe:

b). What do you believe is the best way to deal with?
depression?

4. How common is depressive disorder among your patients in the area? How frequent are people seeking help for depression? If it is frequent, what do you think is the factors of that increment?

5. How many patients are you treating on average? Per day_____Per week: ______

6. How do you diagnose depression? (Probing), is there any concerns do these diagnoses commonly cause to your patients? If so, what kinds of concerns do your patients usually face?

7. In the general sense, how severe is depression as a health problem in the area you are serving?

II. Recently, Ethiopian mental health care has become more decentralized to regional hospitals, clinics and psychiatric units. Major supports form the global organizations such as global mental health initiatives and world health organization has been distributed different resources to scale -up Ethiopian mental health care. And depression is considered as one of the severe population health issues which needs treatment at primary health care settings. From your perspective:

1. Is there any change over time? If so, would you please tell us what kind of changes you observe in terms of detecting and handling depressive illness?
2. From your perspective, what do you think is the benefit? (Probing) availability of medication, and other resources? And is there any kind of draw backs too? if so, could you
3. How is the availability of medication in handling depressive illness? And what kinds of medication?
4. Is there any challenges in the process of identifying depression? What common local idiom patients usually used to express their concerns depression?
5. Is there anything else to add**?**

Thank you very much.

Appendix I: Amharic version of In-depth Interview Guide for Healthcare Professionals

ለጤና እንክብካቤ ባለሙያዎች የቃለ ማጠይቅ መመሪያ

ለጤና እንክብካቤ ባለሙያዎች የቃለ ማጠይቅ መመሪያ

የጥናት ርዕስ፡ አለምአቀፍ የአእምሮ ጤና፣ ባዮፖለቲካ እና ጭንቀት በኢትዮጵያ መመርመር፡ የኢትኖግራፊ ጥናት

የግል መረጃ:

የቃለ ማጠይቅ ቀን፡- ___________

የቃለ ማጠይቁ ጊዜ፡- ___________

የቃለ ማጠይቁ ቦታ፡- ___________

የቃለ ማጠይቅ ሰዓታት፡- ___________

የተሳታፊ ኮድ ___________

1. ጾታ

2. የጋብቻ ሁኔታ

3. ዕድሜ

4. ሃይማኖታዊ ግንኙነት

5. የሙያ / የባለሙያ ዓይነት

6. የመደበኛ ትምህርት ከፍተኛ ደረጃ

7. በሆስፒታል ውስጥየዓመታት አገልግሎት

8. ሌላ የግል መረጃ

I. **የመንፈስ ጭንቀት ጽንሰ ሀሳብ፡ አገላለጽ, እና መንስኤ**

1. ከታካሚዎ አንዱ የመንፈስ ጭንቀት እንዳለበት እንዴት ያውቃሉ - ምልክቱ ምን ሊሆን ይችላል ብለው ያስባሉ? በተለይም ምልክቶቻቸውን ለማለየት የትኞቹን ዘዴዎች/መሳሪያዎች ይጠቀማሉ? ካለ እነዚህን የማለየት መሳሪያዎች ስለማጠቀም ምንም ተግዳሮት አለ? እና ምንድን ናቸው?

2. የጤና አጠባበቅ ሰራተኞች የመንፈስ ጭንቀትን ለማከም በዚህ የመጀመሪያ ደረጃ የጤና እንክብካቤ ቦታ ላይ የሚጠቀሙባቸው አለምአቀፍ መመሪያዎች አሉ?

Appendix J: Recruitment Flyer Text for Inviting Patients.

Study Title: Examining Global Mental Health, Bio-politics and Depression in Ethiopia: An Ethnography Study

Research Participant is needed!

We are looking for individuals who are:

1. Living in Bairdar city and surrounding areas
2. Currently experiencing some sort of depression and have been diagnosed with depression at Felege Hiwot referral hospital and Tibebe Ghion Specialized Hospitals, in Bahirdar city
3. At least 18 years old or older

If you answered "yes" to all the above, then you are eligible to participate in a research project which explores the conception of depression in Ethiopia. The main purpose of this study is to explore the meaning and management of depression among patients' diagnosis with depression and mental health care workers in the clinical setting, Bahirdar city, Northern Ethiopia. You are invited to participate in an individual interview to share your experience about depression.

Please contact ________ at +_________ to set up a 45-60 minute in person interview.

Appendix K: Recruitment Poster for Health Care Providers Enrolment

Study Title: Examining Global Mental Health, Bio-politics and Depression in Ethiopia: An Ethnography Study

Research Participant is needed!

We are looking for individuals who are:

1. Living in Bairdar city and surrounding areas
2. Currently working as a mental health professional and provide clinical service at Felege Hiwot referral hospital and Tibebe Ghion Specialized Hospitals, in Bahirdar city
3. At least working at these Hospitals for the last six months.

If you answered "yes" to all the above, then you are eligible to participate in a research project which explores the conception of depression in Ethiopia. The main purpose of this study is to explore the meaning and management of depression among patients' diagnosis with depression and mental health care workers in the clinical setting, Bahirdar city, Northern Ethiopia. You are invited to participate in an individual interview to share your professional about the conception of depression and the challenges you might face to treat depression in the primary health care setting in the Ethiopian context.

Please contact ___________ at _________ to set up a 45-60 minute in person interview.

Appendix L: Telephone Script—For Initial Contact with Potential Participants.

Hello,

Thank you for calling to find out more about our study. I am returning your call to provide more information about our research study.

My name is _______ I am a doctoral student at Western university, conducting this study. The study is being supervised by _______from Western university, Canada. The study will look at how depression is conceptualized among people how are diagnosed with depression and mental health care workers in bahirdar city. Specifically, we want to understand how whether individuals who are diagnosed with depression at Felegehwot hospital and Tebebe Ghion specialized hospitals defined/understand depression and explore their perspectives about the causation, meaning and management of depression. Would you be interested in hearing more about this study?"

If no, I will thank them for their time and say good-bye.

**If yes, I will continue explain study details to them based on the Letter of Information as follows:*

We will be asking people to complete a series of in-depth interviews about their illness experience about depression, their personal views and belts about the causes depression and help seeking behavior and so on. It will last approximately one hour to complete the in-depth interview. But before enrolling participants in this study, I would like to provide a letter of information and consent form for you to review and decide to be part of this study. You will have a week to review and get back to me. I wonder if you are interested to meet at the

Felege Hiwot Hosptial or Tibebe Ghion hospital Psychiatric Units room number (____ ___) we arranged a room for this purpose.

If, the Caller is interested.

I will continue the conversation and will ask the question: I would like to know which date and specific will be the appropriate time to meet?

Thank you for taking the time to talk with me today. If you have still have any questions or concerns, please feel free to contact. I look forward to meeting you soon.

If No, I will thank them for their time and call will be ended.

12 Curriculum Vitae (Very Brief)

Gojjam Limenih, PhD (A.B.D)

Lecturer, School of Health Science (SHS), Faculty of Health Sciences, Western University

Research Associate, St Joseph Health Care, London,

Lawson Health Research Institute, London, ON, Canada

About me: I am a critical global public health and mental health researcher and academic who has been working as a senior lecturer and researcher in the School of Social Work and Health Sciences at the University of Gondar, Ethiopia. I have over a decade of progressive work experience, including university teaching, public health and mental health research, and community mental health outreach programmes in Ethiopia and Canada. I am currently a Ph.D. candidate (A.B.D.) in Health and Rehabilitation Science the field of Health Promotion, specializing in global mental health at Western (UWO). I am currently a sessional lecturer at Western University's School of Health Studies and a Global Mental Health Research Fellow working with Dr. Arlene MacDougall, Department of Psychiatry. I am also a Research Associate working for Dr. Cheryl Forchuk for the Mental Health Nursing Research Alliance (MHNRA) at the Lawson Health Research Institute, St. Joseph Healthcare, London. My research interests are primarily in the areas of mental health systems, global mental health, mental health and illness across life courses, global health research ethics, and mental health care research. Specifically, my research interests and expertise include critical analyses of global mental health interventions, policies, and practices; global health, mental health care in resource-limited settings; depression; gender and mental health; and mental health and addiction, serious mental disorders(SMI) ; cross-cultural psychiatric research and psychiatric research ethics. As a researcher, I aim to provide innovative yet practical solutions to pressing global mental health challenges. I also aim to approach research questions from a multidisciplinary perspective, allowing for rich and diverse interpretations and, consequently, solutions. I also have a strong commitment to improving my research skills and knowledge to consolidate the broad knowledge base needed for more complex and independent research.

Education and Training

Name:	**Gojjam Limenih**
Post-secondary Education and Degrees:	University of Western Ontario London, Ontario, Canada **2020-2024: Ph.D.**
	The University of British Colombia Vancouver, BC, Canada **2012-2016: Ph.D. (ABD)**
	Addis Ababa University Addis Ababa, Ethiopia **2007-2009: MSW**
	Addis Abba University Addis Ababa, Ethiopia **2002-2006: BA Honors**

Related work Experience

1. **Sessional Lecturer**, School of Health Studies
   The University of Western Ontario **2022-2024**
2. **Research Associate**, Mental Health Nursing Research Alliance (MNHRA) LAB; St. Joseph Health Care, London.
   Lawson Health Research Institute **2022-2025**
3. **Global Mental Health Research Fellow**; Department of Psychiatry
   The University of Western Ontario **2021-2023**
4. **Senior Lecture and Researcher** (FT), School of Social Work & Health Sciences
   University of Gondar, Ethiopia **2010-2019**
5. **Associate Director, College of Health & Social Sciences Research Centre**
   University of Gondar, Ethiopia **2010-2012**

Selected Publications

1. BOOKS

Limenih, G. (2014) CONDITION OF WORK IN ETHIOPIA: Employment Relationship, Health, and Safety Analysis: Challenges and Prospects" available at https://www.amazon.co.uk/.../dp/3639308603

2. RECENT and Selected ARTICLES

Submitted: **Limenih,** G, MacDougall, Smith MJ, Elysee, N (*2024*):" I mean, what is Depression?" Ethiopian Mental Health Practitioners' Perspectives on Depressive Disorder, BahirdarCity, Northern Ethiopia. (**Under review**). Cambridge Prisms: Global Mental Health

Submitted: **Limenih,** G, MacDougall, Max, S., Elysee, N (*2024*): Understanding Conceptions of Depression Among Patients and Mental Health Care Providers in Bahirdar City, Northern Ethiopia: A Critical Ethnography Study: International journal of *Social Psychiatry: February ,28, 2024*

Submitted **Limenih, G**., Nouvet N., MacDougall, A. (2024): Pacing the Void: Local Suffering and the Global Discourse of Mental Health (revision requested and revision submitted) The International Journal of Social Determinants of Health and Health Services: IJSDOHS-23 0590.R2; original submission, December 2023.

2024 **Limenih, G**, MacDougall, Max, S., Elysee, N (*2024):* "Impaired in Life": Analyzing People's Accounts of Their Suffering": Implications for A Cultural-Ecosocial Approach to Global Mental Health (**Accepted**). International Journal of Social Psychiatry

2024 **Limenih G**, MacDougall A, Wedlake M, Nouvet E. (2024). Depression and Global Mental Health in the Global South: A Critical Analysis of Policy and Discourse. Int J Soc Determinants Health Health Serv. Volume 54, Issue 2, April 2024, Pages 95 107https://doi.org/10.1177/27551938231220230

2024 **Limenih, G,** Nouvet, E. (2024). The Uptake of Critical Perspectives in the Field of Global Mental Health: A Critical Interpretive Synthesis: doi: https://doi.org/10.1101/2024.01.10.24301044

2023 Osifeso, T., Crocker, S.J., Lentz, Smith-MacDonald,L Seliman.M., **Limenih, G.**, Renée S. MacPhee, A., Gregory S., Brémault-Phillips, S., Malloy, D(2023). A Scoping Review of the Components of Moral Resilience: Its Role in Addressing Moral Injury or Moral Distress for High-Risk Occupation Workers. Curr Treat Options Psych (2023). https://doi.org/10.1007/s40501-023-00310-9

2020 **Limenih**. G. (2020). COVID-19 in Ethiopia: Challenges, best practices, and prospects: Humanitarian Ethics Research Network: https://humanitarianhealthethics.net/2020/05/18/covid-19-in-ethiopia-challenges-best-practices-and-prospects/

2020 Wallace, L., Nouvet E., [and 10 others, including **Limenih, G.]** (2020). COVID-19 in sub–Saharan Africa: impacts on vulnerable populations and sustaining home-grown solutions. Canadian Journal of Public Health, https://doi.org/10.17269/s41997-020-00399-y

2019 **Limenih**. G. (2019). Unpacking Deleuze's Transcendental Empiricism in Theorizing Mental Health and Illness as an Alternative framework in Understanding the Social World and Practicing Mental Health; https://www.researchgate.net/publication/368153380_

2018 **Limenih**, G. (2018). Theorizing Mental Health; Ameta-theoretical Analysis: Scrutinizing Critical Realism as an Alternative Framework in Understanding the Social World Better and Practicing Mental Health https://www.researchgate.net/publication/328838454

2018 **Limenih**. G. (2018). Indigenization Discourse in Cross-Cultural Psychiatry in Local and Global Contexts: From "Either-Or" To "When and How': Towards Methodological Relationalism; https://www.researchgate.net/publication/328839324

2017 **Limenih**. G. (2017, December): Exporting Depression? Is Exporting ant-depressants answer the Mental Health Need of the Global South? North-South INKOTA Magazine Suedlink, Vol.182: PP36-375.