

Good Mental Health Care: What It Is, What It Is Not & What It Could Be

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What makes for good mental health care? What are the barriers to good care and, when they can be overcome, what accounts for successful treatment? What does successful treatment and care, in fact, mean? Can they mean different things to different people? If so, how can we think about them in a practical way that is useful to patients, families, and clinicians? On the one hand, from work in fields as various as neuroscience, clinical psychology, and anthropology, we are learning (and rediscovering) more and more about how the human mind works and the many ways that psychological suffering can be preempted and treated. On the other hand, in many ways, the mental health care system is either dysfunctional or working against what we know to be best for psychological and social flourishing – the disappearance, for example, of true “care” from medical and mental health care systems. In this essay, set against the background of diverse perspectives provided by the foregoing essays in this volume, we attempt to frame and address some of these basic questions, giving priority to practical, down-to-earth, lay, and professional considerations.

A person walks into a consulting room (or into a family encounter, clinic, or community mental health center) looking for help with difficult feelings, ideas, or relationships. Their problem may come with a widely agreed upon label, or may at first seem more amorphous. It may not fit neatly into any available category. It may be difficult to articulate in words for the affected person, the family carer, or the professional provider. The person may be ambivalent about classifying their experience as a problem at all. In the clinical setting, they meet a caregiver: a community health care worker, a physician experienced in using selective psychopharmacological agents, a therapist of some variety. Their transaction is pragmatic, concerned with lessening or removing complaints and controlling unwanted experiences. That clinical action entails understanding the problem as clearly as possible and in such a way as to make available an intervention, a treatment strategy that will maximize the benefit while minimizing the harm.

What that strategy ends up being will depend on the nature of the presenting problem and the training, orientation, and expertise of the provider(s). A medication may be used, or a certain kind of psychotherapy will be initiated, an alternative and complementary practice employed, or family – and self – care with exercise, diet, and meditation. If in psychiatry, another kind of somatic treatment may be prescribed such as transcranial magnetic stimulation or electroconvulsive therapy. If in religious healing, prayer and rituals may be undertaken. The affected person (patient, client, supplicant) and provider will then discern if the chosen course proves helpful or not. All of this, and more, is what we are talking about when we talk about mental health care.

From a more academic perspective, the multidisciplinary collection of essays in this issue also demonstrates how mental health care encompasses a wide range of conditions and possible interventions. Different disciplinary perspectives and theoretical frameworks can formulate the same problem in sometimes very different ways and can, therefore, lead to different approaches to treatment that may complement one another or be mutually incompatible (see the essay by Allan V. Horwitz and Jerome C. Wakefield in this issue).¹ While each perspective lays out a problem to be addressed theoretically in its own way, there will be some conditions – usually those with more dramatic or acute signs and symptoms – that nearly all frameworks regard as mental health issues.² Other conditions with more widely shared or subtle characteristics may be thought of by some as within a certain normal range that places them outside the purview of mental health care. Some basic theoretical frameworks represented in this *Dædalus* issue are: biochemical, neurological, genetic, psychological (cognitive, emotional), psychodynamic/psychoanalytic, interpersonal, social constructionist (cultural, moral), and social structural (poverty, class, race).

While some authors are clearly grounded in one or several distinct perspectives, in clinical practice there is always present a blend of influence idiosyncratic to a particular provider, institution, and political economic system. In other words, the theoretical distinctions between different fields and subfields, as well as professions and institutions, have real effect and implications for practice, yet are never wholly representative of day-to-day clinical reality.³ When patient, family, and community perspectives and practices are given primacy in mental health care – as they must, because they constitute most of care – the realities of what such care is about become both more diverse and more widely shared. Think of the emergent perspective of neurodiversity as a popular replacement for professional caregivers' orientation to pathology in an effort to reduce stigma and mainstream differences.⁴ Research and practice, theory and technique, are forever joined and forever in tension with one another.

In psychiatry and psychology, because we do not understand the etiology of psychological problems in the way that we understand the cause of bacterial in-

fection or bone fractures, we also do not understand exactly how our interventions help, or why they help some people in certain ways and not others. The treatment of mental distress and illness, whether by medication or psychotherapy is, therefore, still fundamentally empirical.⁵ And yet that empirical outcome is so connected to different human interests and perspectives that caregiver and care-recipient (as well as family, friends, and other providers) may not fully agree on the outcome.

Let us return to the person in the consulting room. Their problem has been presented and formulated in some manner and an intervention (or nonintervention) has been decided upon. Treatment has begun, and while these more or less explicit steps are taken and evaluated, something else is happening in the clinical encounter (something that happens to some extent in every clinical encounter): a basic human interaction is unfolding and a caregiving relationship of some sort is developing in the context of all the conscious and unconscious hopes, expectations, uncertainties, and fears of both the affected person and the provider, the patient and the healer. This is the heart of care: the intersubjective caregiving-receiving reciprocity. The therapeutic power of this relationship in all fields of medicine has been well known for a very long time. When we speak of “bedside manner,” “the healer’s art,” “the placebo response,” or “therapeutic empathy and presence,” we are drawing on this relationship.⁶ Today it is given increasing attention in the medical school curriculum. Efforts to incorporate language and lessons from the humanities and arts into medical training illustrate the sense that there is something clinically valuable to being a human provider with a human patient.⁷ These endeavors tend to run aground, however, when efforts are made to standardize clinical interactions and enfold them into any sort of algorithmic approach, such as those entailed by bureaucratic uses of one-size-fits-all technology and the structural demands of our “era of high throughput” of patients and procedures.⁸

Measures of true caregiving processes like the quality of therapeutic relationships, the actual time spent interacting, the practitioner’s skills (or lack thereof) in listening and communicating, their emotional support, their presence as an ethical and spiritual act, their clinical judgment and therapeutic decision-making – all fundamental to quality care – routinely go unexamined in everyday clinical work. We measure none of these crucial elements of care in health care systems. Hence, evidence of the quality of caregiving in psychiatry, other mental health professions (except for a few kinds of psychotherapy research), and indeed every other area of medicine is essentially nonexistent. Instead, clinics and hospitals use a bureaucratic sleight of hand: they evaluate institutional efficiency – the cost, speed, and other bureaucratic measures of the performance and outcomes of services – as a substitute for care and call it quality. The actual day-to-day quality of care in mental health, as in the rest of the field of health, is largely unknown because it is not directly, routinely, or systematically examined.

To complicate things further, there are several different ways one might look at and, therefore, evaluate quality in mental health care: there is quality as defined by different academic and industrial research perspectives, quality as defined by the latest practice standards of each profession and institution, and quality as the usefulness (or not) to a particular person in a particular context of care and treatment relationship. The first will always be different depending on what theoretical and methodological perspective is taken (such as biological, psychological, social constructionist, social structural). The second will also be different depending on the official professional, institutional, or governmental guidelines. The third is more likely to be shared, and may even contain a certain universality, owing to the practical, down-to-earth human activity of caregiving and receiving. It is the abidingly human parts in the individual, family, and community context of care that we primarily concern ourselves with in this essay. This is care as exemplified in this volume by Kay Redfield Jamison's descriptions of the lived experiences of suffering and healing among those with mood disorders, and Vikram Patel and Atif Rahman's research on the effectiveness and potential of therapy by lay counselors and community caregivers.⁹

We generally assume that therapists are therapeutic. There is a good deal of quantitative and qualitative data about the treatment outcomes of particular kinds of therapy, and much reportage about their practices, to suggest they are.¹⁰ And yet we also find regular accounts in the media and in the rapidly expanding genre of patient and family member narratives that raise serious questions about just how good, in general, the quality of care for patients' mental health really is.¹¹ As clinicians who work in this remarkably varied field, we are aware that many psychiatrists, clinical psychologists, psychiatric social workers and nurses, occupational therapists, and practitioners from other disciplines often aspire to clinical excellence. But how often does aspiration translate into high-quality care as assessed by patients, families, and professionals themselves, let alone independent observers, the state, or health insurance companies? Because we are also acutely aware of all the financial, bureaucratic, and professional barriers to quality care, we must admit we simply do not know enough about quality of care in the mental health field. What we do know is simultaneously promising and discouraging. And we must recognize openly that much of what we identify as care does not lend itself to the kind of quantification and evaluation that are used in academic medical and public health policy. But the fact that the subtleties of individual relationships cannot be adequately assessed by a randomized controlled trial does not mean that they are not important. There are other, related, essential elements of care that can be measured more readily, such as actual time devoted to face-to-face patient care, the pattern and level of communication, and the minimization of bureaucratic distractions

and financial conflicts of interest, as well as the reduction of ethical failings and iatrogenic harm.

It is past time to implement across the broad range of practices and practitioners the elements of high quality of care, especially for those most vulnerable and marginal who simultaneously have the greatest need and the fewest resources. Access without adequate quality of services is as unacceptable as are efforts at prevention without treatment.

Looking at our own profession, psychiatry, we recognize that in clinics and training programs across the United States, clinicians and trainees are spending hours and hours each day in front of computer screens entering information that has very little to do with the clinical reality of the patients they are treating. It is a serious crisis in psychiatry, as in the rest of medicine. The union of insurance- and liability-driven clinical documentation and electronic medical records that function as billing platforms and convert clinicians into accountants has grown into a bureaucratic nightmare that distorts clinical realities and wastes precious time.¹² Particularly troubling is the sheer hours spent in training and practice on clinically irrelevant documentation that could (and should) be spent providing care; it discourages clinicians and, at worst, makes them feel alienated from their desire to take part in high-quality clinical practice – alienation that is so common it has received extensive media attention as an epidemic of “burnout.” Burnout results in poorer education and socialization for failure.¹³

The model of the mind implicit in this one-size-fits-all systems approach to psychiatric practice is a false one: unidimensional; without nuances, uncertainty, or contradiction; without humanity. That model does damage to both patients and clinicians. Again, the beneficiaries are insurance companies, those invested in growing hospital bureaucracies, and pharmaceutical companies who lobby for their overpriced products to be more integrated into treatment algorithms across entire health care systems. Prioritizing money, not care, has led us to this state of affairs. Even supposedly nonprofit institutions function as businesses seeking profits: a 2016 study found that seven of the ten most profitable hospitals in the United States were nonprofits.¹⁴ In psychiatry, researchers who should know better, and whose findings may even have made them think twice, have gone along with this commercially driven approach because it not only improves hospital finances, but supports their own publication record and career advancement. They have removed the psyche from psychiatry and in its place given primacy to economic growth over subjective and contextual good. It has not been beneficial for those people who have had the most at stake: patients, families, communities, and ordinary practitioners.¹⁵ Sad to say, academic psychiatry by and large has offered little resistance. Instead, it has been all too eager to abandon the complexity of the human reality of care in favor of the artificial stamp of approval of “evidence-based science” (read, efficiency-based metrics) from industries whose primary objective is financial gain.¹⁶

Consider the observations made by Steven Hyman; Anne Harrington; Isaac R. Galatzer-Levy, Gabriel J. Aranovich, and Thomas R. Insel; Helena Hansen, Kevin J. Gutierrez, and Saudi Garcia; and Gary Belkin, among others, in this issue of *Dædalus*.¹⁷ Despite many remarkable discoveries in basic neuroscience about the workings of the brain, the efficacy of everyday treatment for mental illness has not changed much over the past four decades, and once lofty promises remain unfulfilled. Diagnosis is always a problem (due in large part to the subjective and still mysterious nature of most psychological issues) and the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association has become an ever-expanding catalog of arbitrary conditions or “disorders” defined by symptom checklists, many of which are so lacking in evidence for underlying structure that the entire diagnostic system has been rejected by neurobiologists.¹⁸

There are also concerns on the treatment side of mental health practice. That psychotherapy has outcomes that are better or similar to those for medication is a huge consideration.¹⁹ That relatively simple psychotherapy delivered by community peers with limited training is just as effective as any other treatment for certain mental health problems calls into question what the mental health system in every society should look like. And that developments in neuroscience now emphasize two key features of mental life – unconscious processing and the primacy of feelings – signifies that we are in many ways catching up to a conception of human experience that has long been explored in art, music, literature, and psychodynamic psychology.²⁰

When taken altogether, it is no longer surprising that the whole superstructure of our mental health care system seems profoundly stuck. The widespread efforts to turn mental health care into something approximating routine blood pressure management or antimicrobial treatment are at odds with the state of our current understanding of causes and effects, the emergent pictures of the way the mind works, and our sense of what is decent, ethical practice. Small wonder we may not be getting the results we say we want. And small wonder that psychiatry residents and other trainees are feeling dispirited by a system and an administrative apparatus that seem to deny the existence of the very conflicts and complexities that are causing, or at least exacerbating, the suffering of our patients.

The place of psychiatry, and by extension a medical approach to mental health problems, may well have to become a great deal smaller in the future in comparison with the greater mental health care system, as Hansen and colleagues suggest in their essay.²¹ Their advocacy for a public health harm-reduction approach to syndemics of substance abuse, suicide, and homelessness strikes us as the right track. So, too, does Patel and Rahman’s promulgation of a much larger role for community health caregivers in the delivery of psychotherapeutic interventions for depression, anxiety, trauma, and other common men-

tal health problems.²² For example, the available evidence suggests that half of all cases of depression are relatively less severe and respond well to self- and family-care practices, including exercise, diet, interpersonal support, and meditation. From a public health standpoint, then, professional care of depression, like that of other common mental health problems, should be focused on those more-serious chronic cases that do not respond to these first-line interventions and that require expert treatment, including medication and other somatic therapies, as well as more sophisticated and intensive forms of psychotherapy.²³ The same case can be made for a much narrower, limited, and highly specialized role for psychiatry (and clinical psychology) as a referral back-up for mental health care delivered by primary care physicians, nurses, and community care workers. The same specialized back-up would be appropriate for public health harm-reduction services aimed at reducing domestic violence, racial violence, and other forms of violence-based trauma, as well as suffering due to natural disasters that are increasing owing to climate change, as is addressed in this volume in the essays by Jeffrey W. Swanson and Mark L. Rosenberg, Joseph P. Gone, and Hansen, Gutierrez, and Garcia.²⁴

On the other hand, or perhaps even alongside such constrictions, there are ways in which the field of clinical psychiatry could expand. In academic and other medical institutions that continue to pursue a genuine interest in the improvement of care across departments, psychiatry could be a model and active consultation resource for understanding and maximizing the healing power of the caregiving relationship. Even more generally, as the findings of neuroscience continue to grow and attract interest in medical circles as well as the public sphere, psychiatry is well positioned to lead the ongoing integration of medicine with the humanities, sciences, and arts, while also continually articulating and adhering to the boundaries of our current knowledge, a principle that happens to be at the core of effective clinical practice.²⁵

The result of such change would be a wholesale restructuring of mental health care systems. Such a new mental health care system would also require system-wide prioritization of quality of caregiving relationships, clinical communication, and the related elements of high-quality care that we discussed earlier.

Mental health programs, interventions, and policies are still, for the most part, designed and implemented as though mental health problems are there just waiting to be fixed, figured out, or eliminated with the correct medication or therapy. As though our internal divisions and self-deceptions, with their close connections to our local cultural worlds and their strains and conflicts, were just superficial cracks in the inner veneer of otherwise perfectly consistent and coherent psyches and smooth social relationships. It is an arresting irony that the field of mental health has so much difficulty encompassing the unconscious – part of our everyday contexts of lived experience with all its familiar paradox, ambivalence, and confusion.

Still, on a practical level, not all or perhaps even most causes of psychological problems are most usefully traced to unconscious conflicts or divisions within the self. Some should be approached and primarily understood from a genetic perspective. Some are most usefully seen as interpersonal issues. Some post viral. Some neurodegenerative. Some deeply social-structural as the result of grinding poverty and everyday assaults of racism, as illustrated in the essays by Jonathan M. Metzler, Gone, and Hansen, Gutierrez, and Garcia.²⁶ Yet everyone still has to grapple with the reverberations of these biosocial conditions in their mind. So even in instances of genetically based conditions or infections like COVID-19, which can affect the brain and have been so destructive of mental health, as Laura Sampson, Laura D. Kubzansky, and Karestan C. Koenen show in their contribution to this volume, the experiences of true mental health *care* must be suffused with respect for the mysteries and complications of unconscious life.²⁷ The ontology of care in mental health, the *being* element, not just the *knowing* element, requires attention to unconscious life.²⁸ That is likely how interpersonal processes, such as the therapeutic interactions of depressed individuals with their community caregiver peers described by Patel and Rahman, have their healing effect.²⁹ It is how psychotherapy probably works.³⁰ And perhaps it also helps us understand how systems of health care that (explicitly or implicitly) deny the divided and contradictory nature of human experience can be so corrosive of real care.

This problem, unfortunately, is true of all of health care. Health care systems largely limit their vision of patients, families, and practitioners to a simplistic and extraordinarily superficial consumer-provider framing that supports the dominant vision of health economists and business interests. It reduces care to its supply and demand and product-centered characteristics; it is simply an inadequate way of framing caregiving.³¹ It offers only a small space to acknowledge and affirm the pain and suffering of patients, the fear and uncertainty of family members, and the emotional and moral responses of practitioners. That is the complex – psychological, social, and cultural – humanity of human beings. Out of that human care comes the *presence* (or absence of presence) of the protagonists in the hospital's healing dramas and the *reciprocity* that elicits and sustains care in families and communities.³² Care itself is about the work of caregiving through acts like supporting, assisting, being there, accompanying. Because just the opposite of the dominating health policy vision is or should be what psychotherapy is about, it offers both a vision and a practical model for the therapeutic relationship throughout medicine and health care.³³ Yet, as it runs against the grain of existing health care systems, psychotherapy has been marginalized. Neither regarded as efficient or cost-effective enough at the system level. Perhaps the kind of robust support Patel and Rahman's research offers, along with that of others like it, will help prioritize a psychotherapeutic framing of caregiving that is more popular and influential.

The dismissive responses of health program directors and planners make it crystal clear that any serious undertaking to improve the current quality of care will require not piecemeal reform, but rather a thoroughgoing reimagining of what health care is about. We must make more central the real needs and opportunities of people who are struggling to find and offer healing.

In the 1980s and 1990s, one of us (Kleinman) conducted research on mental health problems in China. That research showed a much larger number of people were in need of mental health care than those regarded as suffering from mental illness by Chinese psychiatrists and other physicians at the time. The care available then was limited to psychopharmacological treatment given in mental hospitals or by psychiatrists and primary care doctors in outpatient clinics. Subsequently, as it became increasingly possible to have large-scale epidemiological studies, it was repeatedly shown that the burden of mental health problems in China was in the same ballpark as in the United States and Europe, and that like in those societies, it was worsening. In China, persons with mental health problems can experience high levels of stigma, and Chinese patients with mental illness tend to emphasize their physical symptoms and seek general medical care. It was Kleinman's view, therefore, that the resulting somatic orientation of psychiatrists, which reinforced such somatization, would reduce the likelihood that the Chinese mental health care system would develop substantial psychosocial and psychotherapeutic care approaches. That theory turned out to be completely wrong. Over the past quarter-century, there has been robust development of counseling and psychotherapy in the popular domain of care in China. These therapeutic approaches are delivered by school counselors, psychologists, and an impressive array of therapists of many different kinds. The popularity of various forms of what we would call psychotherapy in today's China is part of a sea change in that society that is most apparent among youth and younger adults, but increasingly involves people of all ages. The upshot is a mental health system that extends well beyond psychiatrists, hospitals, and clinics while, at the same time, the quality of care for mental health problems in hospitals and clinics has increasingly improved. This is a development seen in other countries that points to cultural, political, economic, and social transformations of our time that simultaneously seem to be worsening mental health yet also reducing its stigma and creating much broader and diversified forms of care that people are seeking out to a much greater extent than anyone would have predicted.

The late Paul Farmer – an icon of healing in global health – wrote: “The idea that some lives matter less is the root of all that is wrong with the world.”³⁴ He was talking about the devastating effects of racism and neocolonialism. But he was also pointing a finger at the combined commercial and bureaucratic processes that dominate health care and so much else in the world. As Hansen and co-

authors, Metzl, Belkin, Gone, and others in this issue show, reimagining mental health care in our times must be a call for making *care* the central value and therefore the measure of health care systems. To accomplish that will require responding to poverty and inadequate housing, reforming the failed criminal justice system, and changing other structural forces that treat many people, including the mentally ill, as if they matter less. Just as this will require societal reform, it will require support for the complex humanity of patients, families, and practitioners.

Gone's account of historical trauma experienced collectively and individually by Indigenous Americans explains why the ever more popular category of PTSD is inadequate for getting at the incomplete and stalled social mourning and personal grieving in the face of past and present ethnocide and persistent assaults on Native peoples everywhere. Based on research and his own experience as a member of the *Aaniiih*-Gros Ventre Tribal Nation of Montana, Gone joins us and many others in concluding that we need nothing less than to thoroughly reimagine mental health care systems. That critical process of reimagination, Gone goes on to say, needs to begin with acknowledgment and affirmation of the more positive and uplifting value dimensions of tribal life, which in turn can encourage healing and rebuilding of more availing worlds. The trajectory of such Indigenous care has to work through loss and mourning in order to offer a new foundation for human flourishing that, among other things, undertakes psychic repair.³⁵

In this same vein, Finnish-American medical anthropologist Annikki Herranen-Tabibi deploys the resonant term "resurgent care" to describe how Sami elderly in the Scandinavian Arctic teach youth to reclaim and reinvigorate traditional ways of caring for disrupted kinship ties, social suffering, chronic illness, disability owing to aging, as well as climate change's local destruction of the permafrost foundation of their ecosystems, and the burdens of their everyday living conditions. Resurgent care becomes more than Indigenous resistance, but an entire people's *modus vivendi* for working through mourning and resistance to confront social and health inequalities, heal and create the on-the-ground conditions for personal and collective flourishing. This is a quest for the wisdom to repair, reinvigorate, and endure.³⁶

Social mourning and personal grieving involve the stewardship of memories, which need to be cared for just as bodies are cared for by lay persons and professionals alike, as they ritually transition or are psychotherapeutically assisted to act forward. Care of memories is the ethical-spiritual-aesthetic reticulum that underpins trust across distinctive forms of mental health care therapies, thereby enabling the completion of individual mourning and the rest of the healing process. Caring for collective memories at the societal level might offer a means for social care and community healing.

We have landed on a foundational principle for mental health systems everywhere: care must be at the center and can be mobilized in different ways to

strengthen a world or to rebuild individual lives. Life itself is the soul of care: human relationships, presence, the caring for memories, the everyday activities of pragmatic solidarity, accompaniment, meaning-making, and ethical decency. Social technologies, including telemedicine, virtual reality, psychiatric medications, and assistive devices, require that human foundation of ordinary life to maximize human prospects. Political economy and bureaucracy must sustain and strengthen, not weaken, this life foundation of care. Policy and programs, as Swanson and Rosenberg show for the crisis of gun violence in America, require care together with prevention if they are to succeed. The upstream sources of our mental health crises – poverty, racism, destructive institutional bureaucracy, wanton commercialization – require care and control if social and health disparities are to be reduced.³⁷ That means focusing on individuals at the same time as social conditions and social systems. It also means that health care systems must prioritize *care* as their central value ahead of financial gain, bureaucratic procedure, professional codes, and ideological commitments. High-quality mental health care begins and ends with acts of care.

Renowned Boston therapist and teacher Elvin Semrad is said to have described psychotherapy as fundamentally a process of “acknowledging, bearing, and putting in perspective” things that are, initially, unacknowledgeable and unbearable. Embedded in this formulation is the insight that, to some degree or another, our individual and collective suffering and symptomatology come from the seemingly infinite ways that we find to not-know what we know. We automatically, reflexively try not to know something if it is too painful, too frightening, too developmentally inappropriate and therefore impossible to integrate into one’s growing self, or if it sets up a seemingly irresolvable conflict with other things we want, need, and know.³⁸ Call it a defense: denial, repression, dissociation, projection, whatever. Our minds can do this sort of thing because on some level of basic survival it is adaptive; it gets us through but can leave us psychologically mangled. This kind of not-knowing happens on an idiosyncratic, individual level, where an event, a thought, a feeling that is unbearable for one person is perfectly bearable for another with different biology, life history, culture, and so on. It also happens on the level of communities and populations. What else is “the idea that some lives matter less” if not a kind of massive psychological distortion, a denial of something that is as profound as it is self-evident? So why the need for denial? Why is the idea that all lives are of equal value so often unbearable? Probably, at least in part, because of the threat this truth poses to so much of how we operate as individuals and societies, because of the incalculable responsibilities and conflicts and complexities this simple fact brings along with it.

Some of the most foundational work on intergenerational trauma and the repetitive transmission of both dramatic and subtle childhood mistreatment high-

lights various psychological defenses against unbearable feelings as a mechanism for such transmission.³⁹ We avoid complicated and painful truths by repressing, dissociating, and otherwise deadening our emotional knowledge, and we thus increase the risk of reenacting and engendering the same deadening processes in our children. Leonard Shengold and others have called this essentially traumatic process “soul murder.”⁴⁰ Similarly, Donald Winnicott described the “false self” that takes over one’s life when the self-preservative psychological contortions of childhood have been too great.⁴¹ The child, in order not to know what she cannot bear to know, must amputate her whole apparatus for knowing and feeling new things. She must kill a part of herself in order to survive. Gone, in his essay, describes a related process on both an individual and a community level. Just as the defensive denial of the basic truth of human equality can result in actual genocide, so can the unbearableness of such historical trauma subsequently create the conditions for “soul genocide” and the alienation from one’s individual and historical identity on a massive scale. It then becomes not a question of treating PTSD symptoms in any sort of medicalized manner, but rather finding a way, collectively, to mourn a loss that entails acknowledging and bearing those things that have so far been unacknowledgeable, perhaps even psychologically unrepresentable in thought or feeling.

We began this essay by noting the wide range of conditions and experiences that might be encompassed by the field of mental health care. This diversity of conditions, treatments, technical approaches, and theoretical orientations remains and will likely continue to expand. At the same time, we set out to identify and articulate some everyday, down-to-earth, universal aspects of mental health issues and treatments that arise from our shared human condition and transcend, or at least should transcend, the innumerable and inevitable conflicting interests of medical finance and economics, publication and promotion incentives, theoretical allegiances, academic prejudice, bureaucratic inertia, and human desire for concreteness and simplicity, to name a few. There is currently no comprehensive theory of mental illness that accounts for everything we observe from biology to individual experience to social phenomena. Fundamental causes for even the most common issues are still debated, elusive, and overdetermined all at once. So, we must continue to learn more: more neuroscience, more social science, more clinical experience. At the same time, we must recognize that we already know something about what makes for good care and we must promote it. We also know how challenging it can be to bear reality, to be honest with ourselves. How easy, how natural it can be to curate our thoughts and feelings, our memories, and our theories and policies in ways that are both self-protective and self-destructive. Whether a psychological problem arises primarily from biochemistry or psychodynamic conflict, or social conditions, one of the most important roles of caregiving, whatever the technique, is to help one person or many acknowledge and bear a compli-

cated reality that is for all of us, at one point or another, too much to handle on our own. This truth is both daunting and hopeful in its basic, unsophisticated nature. It is also threatening to anyone (truly, all of us to some degree) and any institution that wants to have the authoritative answer, the right treatment. Perhaps that is why it keeps getting ignored – or forgotten.

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ENDNOTES

- ¹ Allan V. Horwitz and Jerome C. Wakefield, “Two Sides of Depression: Medical & Social,” *Daedalus* 152 (4) (Fall 2023): 212–227, <https://www.amacad.org/publication/two-sides-depression-medical-social>.
- ² Psychosis and severe anxiety are recognized almost everywhere. See Arthur Kleinman, *Rethinking Psychiatry: From Cultural Category to Personal Experience* (New York: Free Press, 1988).
- ³ On clinical reality, see Arthur Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry* (Berkeley: University of California Press, 1980), in which clinical reality is defined as an instance of the mutual construction of the social world by participants—patients, networks, practitioners—who come together around a practical problem, and in so doing recreate culture (societal and professional) through their interactions and acts of interpretation, communication, caregiving, and care receiving.
- ⁴ Matthew Wolf-Meyer, *Unravelling: Rethinking Personhood in a Neurodiverse Age* (Minneapolis: University of Minnesota Press, 2020).
- ⁵ See, in this volume, Anne Harrington, “Mental Health’s Stalled (Biological) Revolution: Its Origins, Aftermath and Future Opportunities,” *Daedalus* 152 (4) (Fall 2023): 166–185, <https://www.amacad.org/publication/mental-healths-stalled-biological-revolution-its-origins-aftermath-future-opportunities>; and Steven E. Hyman, “The Biology of

- Mental Disorders: Progress at Last,” *Dædalus* 152 (4) (Fall 2023): 186–211, <https://www.amacad.org/publication/biology-mental-disorders-progress-last>.
- ⁶ Ted Kaptchuk has done groundbreaking work on the psychophysiology of this healing power. See Ted Kaptchuk, Christopher Hemond, and Franklin Miller, “Placeboes in Chronic Pain: Evidence, Theory, Ethics, and Use in Clinical Practice,” *The BMJ* 370 (2020): m1668, <http://dx.doi.org/10.1136/bmj.m1668>. See also Sean R. Zion, Kength-sagn Louis, Rina Horii, et al., “Making Sense of a Pandemic: Mindsets Influence Emotions, Behaviors, Health, and Wellbeing during the COVID-19 Pandemic,” *Social Science & Medicine* 301 (2022), <https://doi.org/10.1016/j.socscimed.2022.114889>; Melissa A. Boswell, Kris M. Evans, Sean R. Zion, et al., “Mindset Is Associated with Future Physical Activity and Management Strategies in Individuals with Knee Osteoarthritis,” *Annals of Physical and Rehabilitation Medicine* 65 (6) (2022), <https://doi.org/10.1016/j.rehab.2022.101634>; and Lauren C. Heathcote, Sean R. Zion, and Alia J. Crum, “Cancer Survivorship-Considering Mindsets,” *Jama Oncology* 6 (9) (2020), <https://doi.org/10.1001%2Fjamaoncol.2020.2482>.
- ⁷ One of the early and most influential works on this subject is Jerome Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy* (New York: Schocken, 1961). For a cross-cultural expansion of these ideas, especially as they relate to Asia, see Karen Laura Thornber, *Global Healing: Literature, Advocacy, Care* (Leiden: Brill, 2020). And for a powerful recreation of William Osler, W. H. R. Ricers, and other exemplary healers in medicine who embodied the elements of psychotherapy in their work of caregiving, see Kay Redfield Jamison, *Fires in the Dark: Healing the Unquiet Mind* (New York: Knopf, 2023).
- ⁸ Kenneth Ludmerer, *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine* (New York: Oxford University Press, 2015).
- ⁹ Kay Redfield Jamison, “Disorders of Mood: The Experience of Those Who Have Them,” *Dædalus* 152 (4) (Fall 2023): 151–165, <https://amacad.org/publication/disorders-mood-experience-those-who-have-them>; and Vikram Patel and Atif Rahman, “Empowering the (Extra)Ordinary,” *Dædalus* 152 (4) (Fall 2023): 245–261, <https://amacad.org/publication/empowering-extraordinary>. The literature on care is quite extensive and crosses professional and popular genres. See the references in Arthur Kleinman, *The Soul of Care: The Moral Education of a Husband and a Doctor* (New York: Penguin, 2019); and in Felicity Aulino, *Rituals of Care: Karmic Politics in an Aging Thailand* (Ithaca, N.Y.: Cornell University Press, 2019).
- ¹⁰ See the work of Jonathan Shedler for an overview of the state of clinical evidence for psychotherapy and an important perspective on the interpretation of various types of evidence with regard to psychotherapy, as well as the complexities inherent in the objective study of subjective states and common misrepresentations of evidence and outcomes in psychiatric and psychological publications. See Jonathan Shedler, “The Efficacy of Psychodynamic Psychotherapy,” *American Psychologist* 65 (2) (2010): 98–109, <https://doi.org/10.1037/a0018378>; and Jonathan Shedler, “Where Is the Evidence for ‘Evidence Based’ Therapy?” *Journal of Psychological Therapies in Primary Care* 4 (2015): 47–59.
- ¹¹ Illustrative of the wider crisis of care are the articles documenting cases of psychiatric polypharmacy: one medication is added to another to manage symptoms and side effects, while the underlying causes and human experiences fade into the clinical background. For example, see Matt Richtel, “This Teen Was Prescribed 10 Psychiatric

- Drugs. She's Not Alone," *The New York Times*, August 27, 2022, <https://www.nytimes.com/2022/08/27/health/teens-psychiatric-drugs.html>.
- ¹² We wrote about this issue in general medicine in 2016. See Caleb Gardner and John Levinson, "Turn Off the Computer and Listen to the Patient," *The New York Times*, September 21, 2016, <https://www.wsj.com/articles/turn-off-the-computer-and-listen-to-the-patient-1474498203>. As the subsequent stream of similar articles and op-eds suggests, the problem remains, and is especially detrimental to a field like psychiatry that relies so heavily on human interaction for both diagnosis and treatment.
- ¹³ Smit Chitre has written a senior honors thesis in anthropology at Harvard University based on an ethnography with clinicians of different generations at a leading hospital that both documents burnout and relates it directly to classical Marxist alienation. In Chitre's interviews, these clinicians feel alienated from the high expectations they have for their work as professional carers and the systemic obstacles that make it so extraordinarily difficult for them to realize these expectations in actual practice. Other reports by researchers and practitioners do not necessarily use the term but convey the same meaning. See Sandeep Jauhar, *Doctored: The Disillusionment of an American Physician* (New York: Farrar, Straus and Giroux, 2015); and Kleinman, *The Soul of Care*.
- ¹⁴ Ge Bai and Gerard F. Anderson, "A More Detailed Understanding of Factors Associated with Hospital Profitability," *Health Affairs* 35 (5) (2016), <https://doi.org/10.1377/hlthaff.2015.1193>.
- ¹⁵ For a particular example of this general phenomenon, see Erick H. Turner, Annette M. Matthews, Eftihia Linardatos, et al., "Selective Publication of Antidepressant Trials and Its Influence on Apparent Efficacy," *The New England Journal of Medicine* 358 (3) (2008): 252–260, <https://pubmed.ncbi.nlm.nih.gov/18199864>. See also Arthur Kleinman, "Rebalancing Academic Psychiatry: Why It Needs to Happen – and Soon," *The British Journal of Psychiatry* 201 (6) (2012): 421–422, <https://doi.org/10.1192/bjp.bp.112.118695>; and Roberto Lewis-Fernández, Mary Jane Rotheram-Borus, Virginia Trotter Betts, et al., "Rethinking Funding Priorities in Mental Health Research," *The British Journal of Psychiatry* 208 (6) (2016): 507–509.
- ¹⁶ Allan Frances, *Saving Normal: An Insider's Revolt against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (New York: William Morrow & Co., 2013); and Robert Whitaker, *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America* (New York: Crown, 2010).
- ¹⁷ Hyman, "The Biology of Mental Disorders"; Harrington, "Mental Health's Stalled (Biological) Revolution"; Isaac R. Galatzer-Levy, Gabriel J. Aranovich, and Thomas R. Insel, "Can Mental Health Care Become More Human by Becoming More Digital?" *Dædalus* 152 (4) (Fall 2023): 228–244, <https://amacad.org/publication/can-mental-health-care-become-more-human-becoming-more-digital>; Helena Hansen, Kevin J. Gutierrez, and Saudi Garcia, "Rethinking Psychiatry: Solutions for a Sociogenic Crisis," *Dædalus* 152 (4) (Fall 2023): 75–91, <https://www.amacad.org/publication/rethinking-psychiatry-solutions-sociogenic-crisis>; and Gary Belkin, "Democracy Therapy: Lessons from ThriveNYC," *Dædalus* 152 (4) (Fall 2023): 111–129, <https://www.amacad.org/publication/democracy-therapy-lessons-thrivenyc>.
- ¹⁸ See the references in Hyman, "The Biology of Mental Disorders."
- ¹⁹ See Vikram Patel, Benedict Weobong, Helen A. Weiss, et al., "The Healthy Activity Program (HAP), a Lay Counsellor-Delivered Brief Psychological Treatment for Severe De-

pression, in Primary Care in India: A Randomised Controlled Trial,” *The Lancet* 389 (10065) (2017): 176–185, [https://doi.org/10.1016/S0140-6736\(16\)31589-6](https://doi.org/10.1016/S0140-6736(16)31589-6); Vikram Patel, Helen A. Weiss, Neerja Chowdhary, et al., “Lay Health Worker Led Intervention for Depressive and Anxiety Disorders in India: Impact on Clinical and Disability Outcomes over 12 Months,” *The British Journal of Psychiatry* 199 (6) (2011): 459–466, <https://doi.org/10.1192/bjp.bp.111.092155>; and Vikram Patel, Helen A. Weiss, Neerja Chowdhary, et al., “Effectiveness of an Intervention Led by Lay Health Counsellors for Depressive and Anxiety Disorders in Primary Care in Goa, India (MANAS): A Cluster Randomised Controlled Trial,” *The Lancet* 376 (9758) (2010): 2086–2095, [https://doi.org/10.1016/S0140-6736\(10\)61508-5](https://doi.org/10.1016/S0140-6736(10)61508-5).

²⁰ Throughout history, observers of human experience in the arts and sciences have, in various ways, grappled with and articulated the everyday phenomenon of subconscious or periconscious mental processing: the fact that much of our lives happens outside of or in-and-out of our conscious awareness. These observations have taken many shapes, from the various models of the unconscious in psychodynamic theory and practices (for a thorough review of the influences on and the evolution of the original formulations of a dynamic unconscious, see Henri Ellenberger, *The Discovery of the Unconscious* [New York: Basic Books, 1981; 1970]), to the growing understanding of dissociation and “split-off” experience in all kinds of trauma (see Bessel Van der Kolk, *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* [New York: Penguin, 2014]), to the self-deceptions and the conflicted, disavowed motivations that govern the lives of the characters in good literature, thereby making them convincingly human. The fact that so much of our experience, so much of our selves, happens off-screen or partially off-screen is often why we find ourselves behaviorally or psychologically stuck in apparently baffling ways. It is also the path by which we can actually grow and change. Harold Bloom, in *The Art of Reading Poetry* (New York: Harper, 2005), has said that while Dante is the poet of a certain fundamental fixity within all of us, Shakespeare is the poet of “a psychology of mutability” based upon self-overhearing. These two simultaneous human conditions, changelessness and change, often seem to be at the heart of what we contend with in the office with patients and in our own ongoing efforts to become who we are. “Consciousness is to poetry what marble is to sculpture,” Bloom says; “words are figurations of consciousness” and “the work of great poetry is to aid us to become free artists of ourselves.” Essentially, this is also the work of clinical mental health care. Now, led by scientists such as Antonio Damasio, neuroscience, too, is contributing to our appreciation of the power and ubiquity of both unconscious and emotional brain/mind processes in basic psychological development, as well as states of illness or distress. See Antonio Damasio, *Self Comes to Mind: Constructing the Conscious Brain* (New York: Partheon, 2010); and Jaak Panksepp and Lucy Biven, *The Archeology of Mind: Neuroevolutionary Origins of Human Emotions* (New York: W.W. Norton, 2012). For a more comprehensive list of neuroscientific publications that address psychodynamic concepts and processes, see Maggie Zellner, “Freud in the Light of Neuroscience: The Brain as the Light of Psychoanalysis,” in *Clinical Studies in Neuropsychanalysis Revisited*, ed. Christian Salas, Oliver Turnbull, and Mark Solms (Oxfordshire: Routledge, 2021).

²¹ Hansen, Gutierrez, and Garcia, “Rethinking Psychiatry.”

²² Patel and Rahman, “Empowering the (Extra)Ordinary.”

²³ See Seth Mnookin, Arthur Kleinman, Timothy Evans, et al., “Out of the Shadows: Making Mental Health a Global Development Priority,” paper presented at the World Bank Group/World Health Organization meeting on making mental health a global development priority, Washington, D.C., April 13–14, 2016, <https://www.emro.who.int>

- /images/stories/mnh/documents/out_of_the_shadows_en.pdf?ua=1. The two-day event was held as part of the World Bank Group/International Monetary Fund spring meetings.
- ²⁴ Jeffrey W. Swanson and Mark L. Rosenberg, “American Gun Violence & Mental Illness: Reducing Risk, Restoring Health, Respecting Rights & Reviving Communities,” *Dædalus* 152 (4) (Fall 2023): 45–74, <https://www.amacad.org/publication/american-gun-violence-mental-illness-reducing-risk-restoring-health-respecting-rights>; Joseph P. Gone, “Indigenous Historical Trauma: Alter-Native Explanations for Mental Health Inequities,” *Dædalus* 152 (4) (Fall 2023): 130–150, <https://www.amacad.org/publication/indigenous-historical-trauma-alter-native-explanations-mental-health-inequities>; and Hansen, Gutierrez, and Garcia, “Rethinking Psychiatry.”
- ²⁵ Caleb Gardner and Arthur Kleinman, “Medicine and the Mind—The Consequences of Psychiatry’s Identity Crisis,” *The New England Journal of Medicine* 381 (18) (2019): 1697–1699, <https://doi.org/10.1056/nejmp1910603>.
- ²⁶ Jonathan M. Metz, “The Protest Psychosis & the Future of Equity & Diversity Efforts in American Psychiatry,” *Dædalus* 152 (4) (Fall 2023): 92–110, <https://www.amacad.org/publication/protest-psychosis-future-equity-diversity-efforts-american-psychiatry>.
- ²⁷ Laura Sampson, Laura D. Kubzansky, and Karestan C. Koenen, “The Missing Piece: A Population Health Perspective to Address the U.S. Mental Health Crisis,” *Dædalus* 152 (4) (Fall 2023): 24–44, <https://www.amacad.org/publication/missing-piece-population-health-perspective-address-us-mental-health-crisis>. In his 2023 *New Yorker* article, George Makari uses the mental health crisis precipitated by the COVID-19 pandemic to examine many of the central points of this essay. George Makari, “What COVID Revealed about American Psychiatry,” *The New Yorker*, July 13, 2023, <https://www.newyorker.com/culture/essay/what-covid-revealed-about-american-psychiatry>.
- ²⁸ Thomas H. Ogden, “Ontological Psychoanalysis or ‘What Do You Want to Be When You Grow Up?’” *The Psychoanalytic Quarterly* 88 (4) (2019): 661–684, <https://doi.org/10.1080/00332828.2019.1656928>. See also Caleb Gardner and Arthur Kleinman, “Medicine and the Unconscious,” *The Lancet* 398 (10295) (2021): 112–113, [https://doi.org/10.1016%2FS0140-6736\(21\)01460-4](https://doi.org/10.1016%2FS0140-6736(21)01460-4).
- ²⁹ Patel and Rahman, “Empowering the (Extra)Ordinary.”
- ³⁰ Frank, *Persuasion and Healing*. See also Frederick T. L. Leong, Jennifer L. Callahan, Jeffrey Zimmerman, et al., eds., *APA Handbook of Psychotherapy* (Washington, D.C.: APA Publishing, 2023); Alice E. Coyne, Michael J. Constantino, Kimberly A. Ouimette, et al., “Replicating Patient-Lived Moderators of CBT and IPT’s Comparative Efficacy for Depression,” *Psychotherapy* 59 (4) (2022): 616–628, <https://doi.org/10.1037/pst0000458>; Michael J. Constantino, Averi N. Gaines, and Alice E. Coyne, “Clients Own Perspectives on Psychotherapy Outcome and Their Mechanisms,” in *The Other Side of Psychotherapy: Understanding Clients’ Experiences and Contributions in Treatment*, ed. Jairo N. Fuertes (Washington, D.C.: APA Publishing, 2022): 317–349; and Mantosh J. Dewan, Brett J. Steenbarger, and Roger P. Greenberg, *The Art and Science of Brief Psychotherapies: A Practitioner’s Guide*, 3rd ed. (Washington, D.C.: APA Publishing, 2018).
- ³¹ Paul Farmer, Arthur Kleinman, Jim Kim, and Matthew Basilio, eds., *Reimagining Global Health: An Introduction* (Berkeley: University of California Press, 2013).
- ³² Kleinman, *The Soul of Care*.
- ³³ Jamison, *Fires in the Dark*.

- ³⁴ Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2004); and Farmer, Kleinman, Kim, and Basilio, eds., *Reimagining Global Health*.
- ³⁵ Gone, “Indigenous Historical Trauma.”
- ³⁶ Annikki Herranen-Tabibi, “Resurgent Ecologies of Care: An Ethnography from Deaneleahki, Sápmi” (PhD diss., Harvard University, 2022), <https://nrs.harvard.edu/URN-3:HUL.INSTREPOS:37372114>.
- ³⁷ Farmer, Kleinman, Kim, and Basilio, eds., *Reimagining Global Health*; and Jason Beckfield, *Political Sociology and the People’s Health* (New York: Oxford University Press, 2018).
- ³⁸ Or, as T. S. Eliot put it in *Four Quartets*: “Humankind cannot bear very much reality.”
- ³⁹ Selma Fraiberg, Edna Adelson, and Vivian Shapiro, “Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships,” *Journal of American Academy of Child and Adolescent Psychiatry* 14 (3) (1975): 387–421, [https://doi.org/10.1016/s0002-7138\(09\)61442-4](https://doi.org/10.1016/s0002-7138(09)61442-4); and Peter Fonagy, Miriam Steele, George Moran, et al., “Measuring the Ghosts in the Nursery: An Empirical Study of the Relation between Parents’ Mental Representations of Childhood Experiences and Their Infants’ Security of Attachment,” *Journal of American Psychoanalytic Association* 41 (4) (1993): 923–928, <https://doi.org/10.1177/000306519304100403>.
- ⁴⁰ Leonard Shengold, *Soul Murder: The Effects of Childhood Abuse and Deprivation* (New Haven, Conn.: Yale University Press, 1989).
- ⁴¹ Donald W. Winnicott, “Ego Distortion in Terms of True and False Self,” in *The Maturation Processes and the Facilitating Environment* (New York: International Universities Press, 1960), 140–157.