B2 Mental health: culture, language and power

In poor countries, mental illness tends to be grossly neglected by health systems. Diseases tend to get prioritised. This chapter discusses the challenges of caring for people with mental illness and emotional distress. However, emotional distress and mental illness are embedded within and cannot be separated from language, and cultural, social and political context. Placing mental health within these contexts is the essence of this chapter. Those who are mentally ill are also subject to stigma, sometimes feared, and sometimes cared for in inhumane conditions. These crucial issues are not addressed directly but are highlighted in some of the case studies that accompany this chapter on the Global Health Watch website.

Mental health problems are wide-ranging and include depression, schizophrenia, anxiety, stress-related disorders and substance abuse. They may be mild and temporary or chronic and severely disabling and affect all ages. Mental health problems also include organic disorders such as dementia and mental retardation (but not epilepsy, which is sometimes wrongly seen as a mental disorder). Poor mental health can also result in poorer outcomes associated with other diseases such as cancer, HIV/AIDS, diabetes and cardiovascular disease (Prince et al. 2007).

The World Health Organization (WHO 2003) estimated that 13 per cent of the worldwide burden of disease is due to mental health problems, although 31 per cent of countries do not have a specific public budget for mental health (Saxena et al. 2007). In addition, each year nearly a million people take their own lives. Rates are highest in Europe's Baltic States where around 40 people per 100,000 commit suicide annually. However, the incidence of suicide is widely under-reported because suicide is considered a sin in many religions, a taboo in many societies, and a crime in others.

IMAGE B2.1 **Young Brazilian girl suffering from mental illness is chained to the wall**

Suicide is among the top three causes of death of young people aged 15–35 (WHO 2000) and is one of the leading causes of death of young women in India and China (Wortley 2000).

In spite of the burden of mental illness across the world, 40 per cent of countries have no mental health policies. Thirty-three countries with a combined population of 2 billion invest less than 1 per cent of their total health budget on mental health (WHO 2005a). More than two-thirds of the world's population (68 per cent), the majority of whom are in Africa and South Asia, have access to only 0.04 psychiatrists per 100,000 of the population, although these areas have an extensive network of traditional practitioners (WHO 2005a).

The social and structural determinants of mental ill health

There is a need to improve the availability and quality of mental health-care services worldwide. However, as mental heath is inextricably linked to the cultural and social fabric in which each person lives, improving mental health must also address negative social and economic factors.

A multiplicity of factors can contribute to either increased vulnerability or the development of resilience – that is, the capacity to cope with adversity. Many factors are associated with emotional well-being. These include self-esteem, optimism, a sense of control, and the ability to initiate, develop and sustain mutually satisfying personal relationships. These factors operate at individual, family, community and societal levels.

The dominant model of health care for mental illness focuses on the individual and family, and on providing treatment rather than on prevention and mental health promotion. While treatment is necessary for conditions that have an organic or physical basis, a large proportion of the burden of mental distress is exacerbated by social and economic factors and is preventable. A list of some of the social and structural determinants of mental health is presented below.

Poverty, affluence and inequality

The interrelationships between poverty, affluence, inequality and mental ill health are complex. Poverty can predispose people to mental health problems, but mentally ill people and their families are also likely to move into poverty. Poor mental health can therefore be both a cause and a consequence of poverty. This risk is exacerbated by factors such as insecurity, poor physical health, rapid social change and limited opportunities as a result of less education (Patel and Kleinman 2003).

When people exist in extreme poverty, material progress can increase emotional well-being. However, when material discomfort has been assuaged, extra income becomes much less important than interpersonal relationships.

> When I don't have [any food to bring my family] I borrow, mainly from neighbours and friends. I feel ashamed standing before my children when I have nothing to help feed my family. I'm not well when I'm unemployed. It's terrible. (Patel and Kleinman 2003)

Rich countries have reached a level of development beyond which further rises in living standards fail to reduce social problems or improve well-being or happiness.[1] Indeed, excessive materialism has been described as a cause of social malaise and is sometimes described as 'affluenza' (James 2007).

While levels of income may have an independent effect on levels of mental well-being, recent evidence suggests that the experience of relative poverty and inequality also has a negative effect on both psychological and social well-being (Wilkinson 2005). Inequality has grown dramatically over the last 300 years, both between rich and poor countries and within countries. Cross-country comparisons demonstrate that countries with a wide gap between social classes will be more dysfunctional, violent and have higher rates of mental distress than those with a narrower gap. Further, poor countries with fairer wealth distribution are healthier and happier than richer, more unequal nations (Wilkinson 2005).

Wilkinson (2006) asserts that inequality is the most important explanation of why some affluent societies are 'social failures'. What is important is the

scale of difference in social status and divisions within a society. This view is also supported by Richard Layard (2006), a UK economist, who argues that social comparison and status competition in affluent societies are significant factors and that happiness is derived from relative, not absolute, income.

Layard also points to the negative effect of constant competition between individuals and companies for status and material possessions. Advertising colludes with this by encouraging people to feel that possessions can make one feel like a more substantial person in the eyes of others. People also continually adapt to higher income levels so that their idea of a sufficient income grows as their income increases, leaving a large number of people chasing an ever-elusive goal.

Globalisation/industrialisation

Linked to the determinants of material well-being and relative social position are the processes of globalisation and industrialisation. Both have fuelled changes in lifestyle and shaped patterns of inequality within and between countries which have had profound effects. Traditional ways of living have been undermined and devalued as consumerism, materialism and economic growth are promulgated and equated with the concept of 'development'. The speed of change is also such that societies are struggling to adapt. Millions of people, who have been forced to leave the land and their traditional ways of life, are now living in alien urban environments, often with little hope of decent employment and forced to cope with the disintegration of family and community structures.

Globalisation has also contributed to hundreds of millions of people living in increasing poverty. In this sense, the rising tide of suicides and premature mortality in many countries can be viewed not just as 'mental health problems' but also as an understandable consequence of the profound despair experienced as a result of the loss of livelihoods and ways of life.

Sengupta (2006) illustrates this despair in his description of how globalisation has affected small-scale farmers in India, who are now subject to unfair competition. Together with the pressure to purchase more expensive genetically modified seeds and susceptibility to monsoons and crop failures, debt and unemployment among Indian small-scale farmers have reached unprecedented levels, and the suicide rate within this group has substantially increased (Patel et al. 2006).

In addition to the movement of people from rural to urban settings, there is increased movement of people internationally. Integration into host countries can be stressful. Forced migration from political violence can magnify the problems, and the mental health of refugees presents ongoing complex needs, some of which are referred to in Chapter B3.

Gender and violence

Gender inequalities are an important social determinant of mental distress. There is a consistent gender difference in risks for common mental disorders in all societies. For example, depression affects twice as many women as men across different countries and settings (Patel and Kleinman 2003). Women's multiple roles as both caregivers and breadwinners, as well as their vulnerability to gender-based sexual violence, are contributory factors. In low-income countries, women also bear the brunt of the adversities associated with poverty, and have less access to school (Wortley 2006).

The relationship between violence and mental health is complex. Domestic violence is ubiquitous and usually directed towards women; political violence creates fear, injury and loss of loved ones and disruption of the social fabric of society. Both are associated with stress and mental disorder. In political violence there may be gender differences in that young men are more likely to take up arms and be casualties, whilst women are left isolated and without means of support.

Children are also deeply affected by political violence and in some cases are even recruited as child soldiers. Mental well-being requires stable caring relationships; violence is the antithesis of this.

Exposure to poverty, inequalities and injustice may contribute to both mental distress and violence, independently of each. Violence may cause mental ill-health, though not all who experience violence develop mental health problems.

In some societies, the mental health system has been used as an instrument of social control and even repression, as was the case in the former Soviet Union. McCulloch's (1995) review of the history of psychiatry in Africa reveals how it was entwined with the ideology of colonialism.

Language, explanatory models and power

Although common biological factors underlie some forms of mental illness across all societies, explanatory models for mental illness and emotional distress are embedded within the assumptions and belief systems of the prevailing culture.

However, those whose language and explanatory models exert greatest power also hold the power to determine and label mental distress. In an increasingly globalised world, it is mainly the materialistic, secular and scientific ideologies of the West that dominate thinking, particularly in international organisations. For example, in 2007 *The Lancet* published a prominent series on global mental health, wherein contributors argue for the universal applicability of Western models. They pay little attention to

BOX B2.1 **The importance of language**

In Afghanistan, *mualagh* denotes a feeling of floating in sad uncertainty, like a leaf held aloft only by gusts of wind; in Darfur, *mondahesh* means a sense of shocked surprise; and in East Timor, *hanoin barak* denotes a state of thinking too much. How do these concepts, rooted in local cultural contexts and understandings, relate to Western mental health concepts, if at all?

The problem is not simply one of 'translation'. Every language carries within it all the assumptions used by a society to make sense of the human condition, including inner feelings and emotional distress. These assumptions contain what people *believe* to be 'true' in relation to mental health problems. Just because emotional reactions to distressing circumstances can be found worldwide does not necessarily mean that they *mean* the same thing for people everywhere.

the role of traditional healers and make scarce mention of the essential role of language and culture.

The globalisation of Western approaches can sideline the articulation of local understandings of mental distress in indigenous languages and sometimes ignore or pathologise the religious and spiritual dimensions of human experience.

One of the features of Western mental health approaches is an individualistic view of self. Separateness, independence, and the capacity to express one's own views and opinions are both explicitly valued and implicitly assumed. The reductionist neoliberal scientific method favoured by the West tends to reduce phenomena into parts, including how human beings are perceived. Individualism and the scientific approach are coupled with ideologies of consumerism, individual choice and individual fulfilment.

Many non-Western cultures socialise children into a different sense of self where priority is given to connections and interrelationship with others as the basis of psychological well-being. The health of individuals is dependent on, and not separate from, healthy relationships with the wider social, cultural and natural environments – ancestors, the community and the land.

In all societies families and communities are the first line of support when someone experiences emotional distress. How families make sense of what is happening and what they perceive needs to be done cannot be separated from their language, values, assumptions and culture. Socially constructed explanations shape the way people make sense of chaotic and

confusing feelings (biochemical cause or evil spell), determine who is socially sanctioned to heal (psychiatrist or shaman), and what people believe will help (Prozac, ECT or rituals to appease the ancestors). The diversity of these assumptions reflects the many ways of making sense of human experience within a multitude of cultural traditions.

Western mental health programmes which focus on the individual have sometimes been inappropriately applied to socio-centric cultures. In societies where recovery for the individual is intimately connected with recovery for the wider community, this can be potentially harmful and undermine communal support systems.

A specific feature of most Western models in mental health is the identification of symptoms, which are then collapsed into a specific diagnosis. This diagnosis is then used to determine 'treatment'. In this model different individuals with similar constellations of symptoms would be likely to receive similar treatment. Cultural, religious and other social factors and unique life histories are considered less relevant to the diagnostic and therapeutic process.

One diagnosis that is the subject of considerable controversy is Post-Traumatic Stress Disorder (PTSD), a term used to describe a severe or prolonged constellation of particular physical and psychological reactions to deeply distressing events. Some of the symptoms of PTSD include intense fear, helplessness, and recurrent, intrusive and distressing recollections of the event; recurrent dreams of the event; acting or feeling as if the traumatic event were recurring; avoiding the place or associations with the trauma; emotional numbing; outbursts of anger; and somatisation (the manifestation of psychological distress through physical symptoms).

After traumatic events such as war, violence and natural disasters, many of the 'symptoms' typical of PTSD tend to be present. However, the significance of those symptoms is dependent upon social, economic, environmental and cultural factors. The ways in which individuals react emotionally to an adverse event are also dependent on past experiences; on the availability of coping strategies and emotional support available from others; on perceptions, understanding and meanings attributed to what is happening; and on perceived capacity to take effective action and plan for the future.

All these variables interact with social, religious and cultural norms in complex ways to determine how someone will react psychologically to trauma *and* how they will recover. The substance of the debate regarding the universal applicability of a diagnosis of PTSD (and associated treatment) is that it does not take these additional factors sufficiently into account.

Many people are resilient and appear able to deal with even quite severe traumatic events, especially if meaningful social structures remain, but there

is a danger that Western medico-therapeutic approaches focus on individuals to the exclusion of social factors. These approaches also tend to focus on concepts of forgiveness and acceptance rather than on the need to find a social and moral meaning for the traumatic event. This may include a demand for justice, accountability and punishment of perpetrators, rather than 'acceptance'.

The spread of PTSD as a universal diagnostic category is another reflection of the worldwide influence of the West's medically based way of understanding distress. As Derek Summerfield (2003) comments, 'Western mental health discourse introduces core components of Western culture, including a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority. None of this is universal.'

The Western, biomedical approach to mental illness also promotes an approach to 'treatment' that is heavily based on pharmacology. This not only benefits the pharmaceuticals industry, but also creates a privileged position for the medical profession. While psychotropic medication *can* be beneficial for several conditions such as psychoses or bipolar disorders, the increasing use of pharmacological treatments can also undermine other approaches to treatment and care which may be more rooted in local culture.

Mental health in humanitarian aid programmes: a steep learning curve

Ever since the Rwandan genocide and the Bosnian conflict in the early 1990s, health professionals have been grappling with how to address the mental health needs of those affected by humanitarian emergencies. 'Psychosocial' and mental health interventions now draw increasing amounts of donor funding, although vigorous debates about the appropriateness and effectiveness of interventions are ongoing.

Responses from aid agencies following disasters should be underpinned by the principle of supporting and understanding local concepts, perceptions and strategies, which may prove very difficult in practice. Aid workers responding to a disaster may have little local experience or understanding, and pressure from donors may require the implementation of a programme within a short time frame coupled with 'evidence of impact'.

There have been major divisions among Western mental health professionals regarding the severity and prevalence of mental health problems in humanitarian emergencies, particularly in relation to 'trauma'. The debate centres on whether wars, disasters and other humanitarian emergencies generate enormous mental health needs, as is sometimes claimed, and

BOX B2.2 **Fishermen from Sri Lanka**

'We are fishermen and we need space in our houses – not only to live but also to store our fishing equipment. After the tsunami we have been living in this camp, which is 12 kilometres away from the coast and in this place for reconstruction. When the international agency came and started building a housing scheme, we realised that they are building flats, which is not suitable to us. But when we try to explain this to the foreigners who are building this scheme, they looked at us as if we were aliens from another planet. What are we supposed to do?'

'I came to the village the day after the tsunami to look for my children but the guards had already put a fence up. I begged them to let me in but they said it was their land and they would be building a hotel. They held their guns and said that, if I didn't go, I would join those who died in the tsunami. We have lost our families, now we are having our homes stolen too.'

Source: Action Aid International 2006.

whether individual treatment of trauma symptoms or the restoration of the cultural, social and communal fabric should take precedence. The recent synthesis of differing views by WHO (2005b) concludes that there is no consensus regarding the appropriateness of Western-type interventions in non-Western settings.

These issues received particular attention and stimulated worldwide debate in relation to the response to the tsunami in early 2005. After the tsunami many NGOs sought to provide 'mental health assistance', utilising the underlying assumptions of, and believing in, the universality of Western psychological models of distress, including underlying assumptions about the individual nature of trauma. Most were ignorant of local culture and traditions and did not have an understanding of the location of personal identities within a communal society. But was mental health assistance what local communities themselves were seeking? Were their voices heard? How appropriate are mental health interventions if people are losing their access to land, water, natural resources and social services?

Experiences of some mental health interventions have led a number of people to question whether external mental health 'aid' had actually been harmful. In Sri Lanka, the concept of an individual without his/her community does not exist. Positive self-identity is based on harmonious relationships with family and community. A woman is not simply an

individual person – her identity is tied to her being a mother, daughter, wife, grandmother and through her work as a farmer or teacher. So, too, for men, children, youth, the elderly and people with disabilities. This identity provides them with a place in the world, including respect and honour. It is in a social setting that those who need help reveal themselves and that the processes which determine how victims become survivors are played out over time.

Inappropriate interventions which afford people only a passive role, for instance awaiting a cure delivered by outside (or inside) 'experts' who depend on Western knowledge, may aggravate feelings of helplessness and vulnerability. Western mental health models involving expertise, training and a new language of medico-therapeutics may contribute to this and devalue local articulations and understandings of distress, undermining some of the local, time-honoured processes that offer protection at a time of crisis.

How are these potentially incompatible approaches to understanding the nature of personhood and identity resolved? Are mental health 'experts' and the trauma industry ready to acknowledge the limited validity of Western psychiatric and psychological formulations, and Western-style counselling, in settings like Sri Lanka?

Despite the limitations of their current form, mental health issues are slowly moving into the mainstream of the humanitarian aid agenda. In 2007 the Inter-Agency Standing Committee (IASC) Task Force on Mental Health and Psychosocial Support published comprehensive guidelines and minimum standards on 'Mental Health and Psychosocial Support in Emergency Settings'. These take a holistic approach, attempting to promote emotional well-being in all areas of aid provision – from sanitation and shelter to psychosocial programmes, psychological self-care for aid workers, and identification and care of the mentally ill.

What needs to be done?

This chapter has highlighted issues of language, culture and power and the importance of context in understanding and responding to mental distress, and also briefly described the main social and structural determinants. This section highlights some conclusions and recommendations.

Advocate for mental health

Caution is required in the application of a scientific ideology which divides human beings into parts rather than seeing people as whole within their own social, political and cultural context. Ancient medical systems such as

Ayurvedic and Chinese medicine took such a holistic view, seeing mind, body and spirit as inseparable. Thus there is the paradox of advocating strongly that mental health and emotional well-being need greater attention in government policies, plans, international NGOs and every aspect of society, but at the same time also advocating for a holistic view of human health. There have been calls for the inclusion of mental health within the framework of the Millennium Development Goals (MDGs), especially because of their influence on policy development and resource allocation decisions, but ideally all MDGs need to incorporate mental health.

At the present time, even when recognising the need for a holistic approach to health, the 'no health without mental health' (Prince et al. 2007) mantra still has to be articulated loud and clear when so much of human economic, social and political activity is inimical to emotional well-being and actively harmful to mental health.

Challenge Western, medico-centric concepts of mental health

Although Western-based mental health care is not homogeneous, a biomedical and highly individualised strand of Western psychiatry has tended to dominate and influence much of the formal global approach to mental distress. Some aspects of this model and system of practice have a role to play, but the limitations are often minimised. It is particularly important that there is a far more extensive critique of the assumptions underlying Western approaches to mental health care. Such reflection is essential to minimise cultural imperialism and to ensure the necessary degree of respect and care when working in very different cultural contexts.

Above all, there is a requirement for mental health professionals and policymakers to listen, respect and understand how people make sense of emotional distress within their own culture and language. They need to learn and work with the 'untranslatable' (it has been suggested that a worldwide database of indigenous expressions describing experiences of mental distress be developed), and to tailor all therapeutic interventions to the social context.

Promote integration

In spite of enormous cultural differences, certain characteristics of the process of healing appear to be common across different societies. These include:

- an emotionally charged, confiding relationship with a helping person (often with the participation of a group);
- a healing setting;

BOX B2.3 **Traditional healing: Mbarara case study**

Over 90 per cent of mentally ill patients who come to hospital first go to traditional healers (THs). During hospitalisation some patients continue consulting THs while others talk of consulting them after discharge to perform certain rituals or ceremonies. It is a common belief among the majority of our people that witchcraft, sorcery, the evil eye, the breaking of taboo or the neglecting of rituals for ancestral spirits cause mental illness. This explains the reason why THs are consulted.

THs occupy a key position in the community. They see and treat many people with mental problems. They distinguish illnesses according to various physiological systems as in the modern Western system. THs also use psychotherapeutic techniques which include reassurance, suggestion, manipulation of the environment, and ego-strengthening elements such as reciting incantations and the wearing of prescribed amulets. Many THs have described this approach as *siyasa* (psychological manipulation).

The concept of treatment from the TH's point of view often transcends the physical, emotional and psychological to include the social and spiritual parameters. It involves man's relationship with the past, the present and the future and with spirits, especially of ancestors. In addition to psychotherapeutic techniques, herbs are administered. We have identified both good and harmful practices. However, through discussion, good practices have been encouraged. Harmful practices such as starving, tying up patients or cutting the skin of various patients using the same razor blade have been discouraged. THs now recognise the danger of using the same blade on different people and have willingly accepted change. While THs can treat various kinds of psychological problems, they do not have the means of treating severe mental disorders. Traditional and scientific approaches must therefore be seen as complementary.

Source: Case study submitted by Elias Byaruhanga (Uganda).

- a rationale, conceptual scheme or even a myth that provides a plausible, culturally appropriate explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them;
- a ritual or procedure that requires the active participation of both patient and healer, and that is believed by both to be the means of restoring the patient's health (Frank and Frank 1991).

Many traditional approaches to healing are effective because they are embedded within local social and cultural structures, but, as with all

mental health care, they are by no means perfect. Western psychiatry, traditional healing and systems of self-caring have both benefits and limitations. However, a greater appreciation of the strengths of indigenous or traditional healing practices and their underlying cultural assumptions could help lead to a more appropriate integration of and synergy between different systems and models of care. The case study in Box B2.3 illustrates the successful integration of traditional and Western approaches to mental health care.

Generating such joint working has significant implications for the training of all mental health professionals. The capacity to integrate different cultural perspectives needs to be at the core of the curriculum for the training of formal mental health professionals in both Western and low-income countries. This would enable them confidently to work across and between different cultures and languages, rather than being trained in the application of Western approaches. Even today, the training of mental health personnel in low-income countries can still be based on a Western curriculum that ignores the local language and cultural context, and some who train in Western countries even become ashamed of their own culture. Those with knowledge of indigenous language, practices and beliefs should be seen as exceptionally valuable resources and should not have to abandon that understanding when they begin professional training.

Promote a holistic approach to mental health

Improving psychological and emotional well-being should be made a primary aim of public policy not just within the health sector, but also in the education, housing, employment, trade and justice sectors.

The elimination of poverty, a reduction in social and economic disparities, respect for women, the acknowledgement, understanding and acceptance of cultural diversity and language must all be essential components in national and global health plans. Although mental health is gradually receiving more attention, a holistic approach to well-being and the inclusion of mental health as a cross-cutting feature of national health plans and poverty reduction strategies remains elusive.

Research

There is a need for greater dissemination of research on the effects of culture, language and social structure on mental illness. This must be accompanied by a commitment to extend further and develop an appropriate evidence base. Western research methods themselves are a product of a specific 'scientific' way of understanding phenomena and can be ill-suited to capturing the emotional, spiritual and existential dimensions of human existence and challenges brought about by globalisation, economic reforms

and political processes. There is much to be learned from other disciplines, particularly anthropology.

There is also a need for more detailed and thoughtful analysis of the policies and programmes of the key global and international health institutions such as the WHO and the World Bank. To what extent do they promote a holistic and culturally appropriate model of mental health care? If funding for mental health programmes is expanding, how exactly is this extra money being used?

There is no doubt that great progress has been made in bringing mental health issues into the mainstream, and that this presents increasing opportunities for funding, programmes and developing of services. The experience of emotional distress is part of being human, and a concern for mental health is one of the commonalities that unites all people and all societies. However, mental illness, emotional distress and psychological well-being are expressed through a myriad languages and cultural and social contexts. We have the knowledge and understanding to rise to the challenge of recognising the commonalities we share while still being able to safeguard our own uniqueness as human beings. Will our social and political systems allow us to turn that understanding into a reality?

Notes

1. For more information, see www.happyplanetindex.org.

References

Action Aid International (2006). *Tsunami response: A human rights assessment*. www.actionaid.org.uk/_content/documents/tsunami_HR01.pdf.

Frank, J.D., and J.B. Frank (1991). *Persuasion and healing*. Baltimore MD: Baltimore University Press.

James, O. (2007). *Affluenza*. London: Vermillion.

Layard, R. (2006). *Happiness: Lessons from a new science*. London: Penguin.

McCulloch, J. (1995). *Colonial Psychiatry and the African Mind*. Cambridge: Cambridge University Press.

Patel, V., and A. Kleinman (2003). Poverty and mental disorders in developing countries. *Bulletin of the World Health Organization* 81(8): 609–15.

Patel, V., B. Saraceno and A. Kleinman (2006). Beyond evidence: The moral case for international mental health. *American Journal of Psychiatry* 163(8), August.

Prince, M., et al. (2007). No health without mental health. *The Lancet* 370: 859–77.

Saxena, S., et al. (2007). Resources for mental health: Scarcity, in equity and inefficiency. *The Lancet* 370: 878–89.

Sengupta, S. (2006). On India's farms, a plague of suicides. *New York Times*, 19 September.

Summerfield, D. (2004). Cross cultural perspectives on the medicalization of human suffering. In G. Rosen (ed.), *Posttraumatic stress disorder: Issues and controversies*. London: John Wiley.

WHO (World Health Organization) (2000). *Preventing suicide: A resource for primary health care workers*. WHO/MNH/MBD/00.4. Geneva. www.who.int/mental_health/media/en/59.pdf.

WHO (2003). *Investing in mental health*. Geneva.

WHO (2005a). *Mental health atlas*. Geneva. www.who.int/mental_health/evidence/atlas/.

WHO (2005b). Mental and social health during and after acute emergencies: An emerging consensus? *Bulletin of the World Health Organization* 83(1): 71–6.

Wilkinson, R.G. (2005). *The impact of inequality: How to make sick societies healthier*. London and New York: Routledge.

Wilkinson, R.G. (2006). The impact of equality: Empirical evidence. *Renewal* 14(1): 20–26.

Wortley, H. (2006). *Depression a leading contributor to global burden of disease*. Washington DC: Population Reference Bureau. www.prb.org.