Urban mental health and the moral economies of suffering in a ‘broken city’: reinventing depression among Rio de Janeiro urban dwellers

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Urban living is frequently regarded as a source of both benefits (e.g. access to public services and labour market) and risks (e.g. violence and pollution) to its inhabitants. The so-called urban paradox (Iossifova, Doll and Gasparatos, 2018) has engaged researchers from different disciplines interested in how urban dwellers cope with life in cities and whether, and in what conditions, the benefits outweigh the risks. In urban health research it is no different. While city living is associated with health hazards resulting from risk factors in the urban social or physical environments (Grant, 2018; Grant et al., 2009; Kjellstrom et al., 2007), it is also associated with better access to health care, education and employment (Gruebner et al., 2017).

Several studies show a negative correlation between mental health and urban living. Mood and anxiety disorders are more prevalent among city dwellers (who have a 40 per cent increased risk of depression and more than 20 per cent for anxiety) than among residents of rural areas, and there is a higher risk of schizophrenia for people who grew up in cities in comparison to rural areas (Peen et al., 2010; Krabbendam and van Os, 2005; van Os, Pedersen and Mortensen, 2004). In Brazil, a nationwide study of depression shows a 50 per cent higher prevalence among individuals living in urban areas (Munhoz et al., 2016).

While city–rural comparison constitutes one area of study in urban health research (the other two being comparisons between cities and
within cities: see Galea and Vlahov, 2005), in this chapter we are more interested in differences within cities, and more specifically we explore the care offered to people with depressive symptoms in primary health care facilities in the city of Rio de Janeiro.

Among the risk factors for mental health originating from the urban social environment, the concentration of low socio-economic status is the most important and shows the most consistent association. Poverty and deprivation are associated with greater risk of depression and schizophrenia (Galea et al., 2007; Rapp et al., 2015). Moreover, urban inequity is related to levels of insecurity and violence in cities, factors that directly influence mental wellbeing (Stephens, Carrizo and Ostadtaghizaddeh, 2016).

Brazilian cities exhibit high levels of urban inequity, and results from the São Paulo Megacity Mental Health Survey statistically associate those living in areas with medium and high levels of income inequality with increased risk of depression relative to those living in areas with low levels of income inequality (Chiavegatto Filho et al., 2013). Moreover, according to the Brazilian National Health Survey, in 2013, the proportion of Brazilians who did not receive any treatment for depression was 78.8 per cent, while 14.1 per cent received only pharmacological treatments. Access to care is scarce and above all unequal, with poor people and those living in low-resource areas having less access to mental health care than other people (Lopes et al., 2016). Beyond the problem of access, there are several reasons for the limited engagement with mental health care among low-income populations. These include the failure to acknowledge that one has a significant problem, the belief that the disorder will resolve itself spontaneously, a desire to deal with the problem by oneself or not knowing where to search for help, a perception that the treatments available are not efficient or are deleterious, and stigma-related barriers (Silva et al., 2013: 288; Van Beljouw et al., 2010; Thornicroft, 2007; Corrigan, 2004).

Understanding these disparities is an important aspect of developing effective mental health interventions, but so is rejecting ‘one-size-fits-all’ approaches. Global Mental Health initiatives recognise alternative, community-based and culturally sensitive approaches from low- to middle-income countries, and reject standardised approaches to treating depression and other conditions (Patel and Saxena, 2014). And yet there is an important tension between the need for locally appropriate and participatory approaches on the one hand, and on the other the
dismissal of those approaches and interventions when they fail to match the standards of evidence-based practices and interventions, particularly efforts to ‘scale up’ and generalise those interventions (Ortega, 2018).

Conditions like depression, with which we deal specifically in this chapter, have socio-economic and environmental determinants for wealthy city dwellers which differ from those for people living in low-income neighbourhoods or urban refugees. Depression can have different manifestations for these individuals, and therefore approaches by mental health professionals have to be differentiated (Stephens, Carrizo and Ostadtaghizaddeh, 2016). These differences call for socially attuned interventions and policies that address the specific cultural and mental health needs of urban dwellers (Caracci, 2006).

Brazil can be considered the country with the highest prevalence of common mental disorders in the world, with the second-highest prevalence of depressive disorders in Latin America (5.8 per cent) and the highest prevalence in the world of anxiety disorders (9.3 per cent) (World Health Organization (WHO), 2017). The São Paulo Megacity Mental Health Survey has shown that this scenario is even more serious in the larger Brazilian urban centres, with a prevalence of 19.9 per cent for anxiety disorders and 11 per cent for mood disorders (9.4 per cent for major depressive disorders) in the Metropolitan Region of São Paulo (Andrade et al., 2012). In addition to the global controversies surrounding the diagnostic criteria of mental disorders and the epidemiological instruments used to measure them, these data point to the significant levels of moral, emotional and social suffering among residents of the Brazilian metropolises. This suffering is associated both with difficulties in their social life and with a lack of capacity to manage other health conditions, especially chronic conditions such as diabetes, obesity, hypertension and chronic respiratory diseases. This chapter focuses on the sociocultural processes and social determinants involved in engendering this urban landscape of suffering, and the local responses to these difficulties within public health services.

‘Hill’ and ‘asphalt’ in Rio de Janeiro

Rio de Janeiro is the second largest city in Brazil, with more than 6 million inhabitants. The city has experienced varying fortunes in recent years, from hosting international mega-events such as the 2014 FIFA World Cup and the 2016 Olympics to being one of the main victims of the
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political disputes that since 2014 have created a serious economic crisis in Brazil. Paradoxes and social divisions permeate the social organisation of the Rio de Janeiro population, which has been studied in the last few decades mainly through the lens of the divide between ‘hill’ and ‘asphalt’. Comparing the reactions of different social strata of the city to an arrastão – a series of simultaneous assaults carried out on a beach in Rio de Janeiro – the Brazilian journalist Zuenir Ventura described Rio de Janeiro in 1994 as a ‘broken city’ (Ventura, 1994). The spatial and housing division is associated with differences in income and access to social rights. In Rio de Janeiro, this division takes on a particular character, because of its peculiar territorial overlap – given the geographical proximity between the ‘hills’ and the more urbanised areas of ‘asphalt’ below – and the intense social conflicts resulting from the structural violence produced by social inequality and armed violence catalysed by illegal drug trafficking.

While other cities, such as São Paulo, could be viewed as ‘surrounded cities’ because of the peripheralisation of poverty, in Rio de Janeiro luxury buildings are situated within a few blocks, or even metres, of hills lacking even basic sanitation, with low income and educational levels. Between 1996 and 2008 the Gini coefficient for social inequality remained stable in Rio de Janeiro and poverty levels actually increased, in contrast to the picture at the national level, where both poverty and inequality rates reduced during this period (Neri, 2010).

This chapter analyses recent transformations in public mental health care in Rio de Janeiro from an ethnographic perspective. At the heart of these transformations was the significant expansion of the Family Health Strategy (FHS) – the primary health care model within the Brazilian universal public health system (SUS in Portuguese) – within the city (Paim et al., 2011; Macinko and Harris, 2015). In 2009 less than 7 per cent of the population in Rio de Janeiro City was assisted by a family health team. In December 2017 the proportion had risen to around 70.6 per cent. In absolute numbers, this means that, over eight years, approximately 4 million additional residents were absorbed into the FHS system (Ministério da Saúde, 2016; Prado Junior, 2015; Harzeim, 2013). This care includes mental health approaches and initial therapeutics offered by a general practitioner, especially for the most prevalent disorders: depression, anxiety and/or use and abuse of alcohol, tobacco and other drugs. Alongside the expansion of primary care coverage, the municipal health secretary instituted Family Medicine as
the largest Brazilian programme of medical residency (currently with 150 positions), in addition to supporting the expansion of programmes in other institutions. In 2010 Rio de Janeiro had sixteen yearly residency positions for Family Medicine. By 2016 that number had increased to 202 (Soranz, 2014).

One of the authors of this chapter (Wenceslau) worked as a family physician in Rio de Janeiro City in 2013 and identified, through informal conversations and in his daily work routine, the presence of discourses and practices among FHS professionals that sought to integrate social and cultural influences into their diagnosis and proposed treatment of individuals dealing with mental illness. To the health care professionals, there were differences both in how mental issues were presented (that is, the narratives and behaviour of patients and family members) and in their causes between those living in the ‘hill’ and those in the ‘asphalt’. Thus we developed an exploratory ethnographic study in order to evaluate how this division was used to both understand and address mental suffering among the Rio de Janeiro population.

In order to carry out the study, we selected a family health unit in the north zone of Rio de Janeiro responsible for the care of approximately 25,000 people, comprising eight teams and covering areas both in the ‘hill’ and in the ‘asphalt’. The unit was located in a middle-class neighbourhood, whose social development index ranked between the tenth and twentieth highest of the 158 neighbourhoods in Rio de Janeiro (Cavallieri and Peres Lopes, 2008). We interviewed thirteen Family Medicine physicians and, of these, selected six to be followed for three months, through participant observation of their activities during consultations, home visits and work meetings. During this period, we also interviewed and closely followed the assessment and treatment of twenty-two patients, twelve of whom lived in the ‘hill’ and ten in the ‘asphalt’.

We also chose to work with a ‘mental health problem’ lens, a native category, used by Family Medicine physicians in order to group together the most common accounts and manifestations of suffering that they designated as ‘mental’. In view of the setting, a public primary health care facility, we focused our investigation on how ‘depressive symptoms’ were addressed. Among the most common mental disorders, depression and anxiety are considered the most prevalent in the general population and in primary care (Lim et al., 2018; Steel et al., 2014), with depression being the single largest contributor to non-fatal health
loss (WHO, 2017). Studies and documents that guide the integration of mental health into primary health care establish that its professionals may and must be capable of identifying and offering resolutive care to patients with mild and moderate depression and also of recognising and following, with specialised mental health care, more severe cases (WHO and World Organization of Family Doctors (WONCA), 2008; WONCA, 2018; WHO, 2016; Wahlbeck, 2015).

In the FHS, professionals are distributed in teams that are each responsible, on average, for 3,500 to 4,000 people (Ministério da Saúde, 2012; Ministério da Saúde, 2017). The six physicians we followed were members of four different teams. We were able to identify an initial repercussion of the division between ‘hill’ and ‘asphalt’, as defined by these teams. Among the four teams we followed, one was dedicated exclusively to the poorer community in the region, while the other three were responsible for the middle-class population. The professionals themselves referred to the poorer community as the ‘hill’ and to the middle-class population as the ‘asphalt’.

To these professionals, there were important differences between the depressive symptoms of these two populations. In the interviews, they stated that the ‘hill’ population was unlikely to present isolated cases of depression, rather presenting mixed experiences of depressive and anxious symptoms and important bodily manifestations (such as diffuse pains, dizziness and fatigue). Patients from the ‘asphalt’, on the other hand, in the view of the physicians, presented more typical cases of depression, characterised by symptoms of profound sadness and withdrawal from social interaction.

Health care professionals also acknowledged the importance of social determinants in the production of depressive symptoms and in their evolution. According to them, in the ‘hill’ people lived more ‘within networks’, and, as a result, the sorrows and suffering they experienced received greater care from the community, leading those individuals to present manifestations and accounts viewed as ‘depressive’ less frequently. These ‘networks’, which worked as mechanisms for social protection and care, were made up of the close supportive relations between neighbours and by the social interaction within different community institutions, such as Evangelical churches, centres of Afro-Brazilian culture and religion, and artistic-cultural associations, such as the community’s samba school. On the other hand, the ‘asphalt’ population had little in the way of networks, with few relationships between neighbours,
distance from family members and low participation in other spaces of social interaction.

In the professionals’ perception, the depressive symptoms experienced by ‘asphalt’ inhabitants manifested the social isolation and financial decline that frequently affected them and that recurred among the older segment of this population. The fact that, over the course of their lives, this population was less exposed to social stressors, such as poverty and violence, had, according to the health professionals, rendered the inhabitants ‘less resilient’ and more susceptible to the development of depressive symptoms when faced with difficulties that, on the other hand, were part of the ‘hill’ population’s everyday lives (for example, unexpected deaths of relatives or friends, lack of food, inadequate housing). However, despite being ‘more resilient’, when presenting depressive symptoms the ‘hill’ population did so more intensely, with many bodily manifestations, including frequent incidences of ‘syncope’ (fainting), as a result of the disruption of nearly all of their social bonds.

To the physicians, ‘somatisation’ in cases of depression was more common among ‘hill’ inhabitants than among ‘asphalt’ inhabitants. This perception is connected with an intense and protracted debate within anthropological studies which, directly or indirectly, has analysed the expansion of public mental health care, including the field’s most recent iteration, Global Mental Health (Patel and Prince, 2010). Since the publication of a number of important transcultural psychiatry works such as ‘Depression, somatization and the “new cross-cultural psychiatry”’ (Kleinman, 1977) and a number of seminal ethnographic studies in various countries – including work on ‘nerves’ and ‘nervousness’ in Brazil (Duarte, 1986; Duarte, 1997) – there has been a discussion surrounding the hypothesis that depressive symptoms, especially among lower-income groups or less industrialised populations, could present themselves predominantly as physical or bodily grievances, as local idioms of distress or even as certain culture-bound syndromes (Kleinman and Good, 1985; Jenkins, Kleinman and Good, 1991). This hypothesis was strongly disputed by authors such as Abas et al. (1994) and Patel (2001; Patel et al., 2001), who pointed both to the importance of the presentation of depression through physical symptoms among more elite and industrialised populations and to the identification of psychological manifestations through ‘culturally adapted’ questionnaires in less Westernised groups. However, controversies remain with regard to the existence of a set of symptoms, however varied in their
composition, that can be seen to globally represent a case of depression: critics point to the risk of incurring a categorical fallacy, that is, a selective recognition of manifestations and phenomena produced by the interest in identifying a certain category within a certain social and cultural universe (Haroz et al., 2017; Kirmayer, Gomez-Carrillo and Veissière, 2017). The different perceptions of depressive symptoms among doctors and patients from the ‘hill’ and those from the ‘asphalt’ observed in this research are an example of the difficulties in establishing such a pattern.

**Therapeutic approaches: ‘social networks’ and ‘patient-centred’ consultations**

The perceived differences between manifestations of depressive suffering among people from the ‘asphalt’ and among people from the ‘hill’ were also translated into distinct emphases in proposed treatments and care, especially through non-pharmacological interventions. The acknowledgement of a ‘lack of networks’ as one of the main causes of depression in the ‘asphalt’ led professionals to insist strongly on offering ‘unit groups’ to those patients. ‘Unit groups’ were social activities led by health professionals for the purpose of offering spaces for social interaction and learning, such as the ‘dance group’, ‘crafts group’, ‘wellbeing group’ and other, more psychotherapeutic groups, such as the ‘cuca fresca’ (cool head) group and the ‘mental health group’, conducted by psychologists. Members of the ‘asphalt’ population were also more frequently referred for individual psychological assessment and more likely to ‘join the queue’ for medium- and long-term psychotherapeutic care.

Evaluation by a psychiatrist from the ‘matrix support team’ was also commonly suggested to the ‘asphalt’ dwellers by physicians. Many of these patients had at one point had better financial circumstances and had not previously used the public health system, but rather private insurance that does not, generally speaking, include primary care services. However, because of crises and changes in their financial situations, they found themselves forced to migrate from private insurance to the public system. Thus the ‘asphalt’ dwellers, accustomed to the specialised services of private insurance companies, would often come to their appointments with the aim of being referred to a psychiatrist or psychologist, without expecting or desiring that a family
physician evaluate or in any way attempt to treat their ‘mental’ needs. Among these patients, there were doubts concerning the capacity of a doctor who is not a psychiatrist to diagnose and treat mental health conditions.

For the ‘hill’ population, we observed that the Family Medicine physicians would more frequently use a series of consultations that they described as following a ‘person-centred clinical method’ (Stewart et al., 2014). These were encounters consisting of dialogues with a therapeutic goal in which the family physician would first encourage the patient to freely describe their experiences. Next, through open questions, they sought to help the patient to promote changes in their practices and behaviour that might reduce their suffering and deliver lasting improvements to their wellbeing.

The use of antidepressant medication was a common therapeutic resource among both populations, but for different reasons. According to the professionals, ‘asphalt’ patients demanded pharmacological treatments more frequently for two reasons. As previously stated, these patients would often seek public services because of financial downturns and, in many cases, had already begun medication treatments that had been previously prescribed by private doctors and that could not be interrupted. Additionally, in the view of the doctors, because of their ‘low resilience’, these patients had difficulties in overcoming depressive symptoms, even low-intensity ones, without medication. Among the ‘hill’ dwellers, those who sought a health service because of mental suffering did so only in severe cases, making cases of depression in the ‘hill’ less frequent but more severe and in greater need of pharmacological treatment.

Contact with health professionals strengthened the hypothesis that differences could be drawn between ‘hill’ and ‘asphalt’. These involved different causes, presentations and approaches to depressive symptoms among the two populations. In order to describe these phenomena from diverse local perspectives, in addition to using the professionals’ accounts, we also investigated the experiences and behaviours of the patients themselves, exploring their perceptions of their own suffering through interviews and visits to the ‘hill’ and ‘asphalt’ territories, and by following consultations. However, when studying these experiences through the perspectives of the patients, we identified limits and problems, which are described below, derived from the use of the ‘hill’/‘asphalt’ categorisation as a way of interpreting depressive suffering
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of people living in a ‘broken’ metropolis such as Rio de Janeiro. These
difficulties are illustrated by the cases of ‘Raquel’ and ‘Pedro’ (fictitious
names).

‘Raquel’

Raquel was a short twenty-seven-year-old black patient with close-
cropped dark hair. She lived in the ‘hill’ and worked as a groomer at
a pet store. In the first consultation we followed, she described having
constant thoughts of killing herself and hearing ‘voices’ whose con-
tensts she was unable to identify. She lived in a small house that had
two bedrooms, one for herself, the other shared by her nine-year-old
daughter and sixteen-year-old son. According to Raquel herself, she
had depression ‘once again’. She had no desire to leave her room, where
she spent most of her time alone, lying down and crying a great deal. In
addition to her suicidal thoughts, Raquel recounted the need to make
small cuts on her arms in order to reduce her unease when it became
more intense. Among the thoughts that troubled her were her many
concerns regarding her sixteen-year-old son, ‘Diego’, diagnosed with
schizophrenia when he was ten years old, in addition to memories from
a period when she lived through an aggressive marriage and the fact
that she greatly missed her mother, who had passed away six months
previously. She did not usually cry during consultations. Reacting to
the questions posed by her physician, she alternated between looking at
him and looking straight ahead while she narrated what she was feeling
and thinking:

I know I have depression and I want to get better. I know I have two
children and they need me, I don’t have relatives, I know I have this
disease, I’m aware and I want treatment. I heard there’s no cure, but
there is a treatment. Depression is this sadness, like, I can’t control
myself when I have to cry. I just have to cry. Things don’t have a solu-
tion for me. When the depression is strong, it makes you want to kill
yourself. Because, like, I think death is rest. Since I lost my mother, maybe
I’m like ‘am I going to meet her? Or not?’ But then my children are the
reason for me to stay. I think if I didn’t have them I would have already
killed myself.

Raquel stated that she had had ‘depression’ crises since she was eight
years old. The first episode was associated with her father’s death, when
she attempted suicide by taking multiple diazepam tablets. Since then, she had had similar episodes associated with specific circumstances in her life. She was divorced, but for eight years she had been trapped in a marriage in which there had been many infidelities and she had been assaulted by her husband. It took her years to leave her husband because of conflicts with her religious practices: at the time, Raquel was an Evangelical Christian. Two years previously, she had managed to leave that relationship, had stopped being an Evangelical Christian and had begun to care for her children in the house she shared with her mother.

The crisis period we followed had been triggered by her mother’s death, which had taken place six months before we met her. Though some time had passed, Raquel’s feelings of mourning for her mother were now intensifying. Her medical practitioner began treatment with antidepressants, in addition to an anxiolytic, clonazepam, in order to stimulate sleep until the antidepressants began to have an effect. Over the course of that same week, there were two follow-up consultations, in which the physicians was particularly concerned with evaluating the suicidal thoughts and the continued presence (or lack thereof) of the ‘voices’. He also sought to promote therapeutic conversations based on a ‘person-centred’ approach, trying to encourage Raquel to return to activities that were good for her, such as practising jiu-jitsu.

The following week, Raquel returned for an unscheduled consultation. During the weekend, Diego had attempted sexual contact with his younger sister. Raquel became anxious and upset and did not know how to deal with this situation. She communicated the situation to Diego’s father, who repeated what he had done in other situations when their son had exhibited violent behaviour: Diego was beaten as punishment for what he had done. According to Raquel, his father was the only person Diego respected, and physical aggression was the most efficient way to calm him down and make him change his behaviour. Diego was also followed by the same medical practitioner, in partnership with the ‘matrix support’ psychiatrist. He was medicated, but in light of this new fact, it was decided that Diego should again be referred to a Centre for Psychosocial Care (CAPS in Portuguese). Though anxious and upset with Diego’s situation, in that second week, Raquel reported that her depressive symptoms had already improved and that she had returned to work.
Over the course of the next three months, Raquel’s ‘depressive crises’ occurred every three to four weeks. Taking care of Diego became harder, and she had to deal with the realisation that schizophrenia is incurable and can become more severe. Raquel was living through a confusing period, torn between whether or not she desired to have a child in her new relationship. Finally, she had been able to begin individual, biweekly psychotherapeutic sessions. The frequent consultations with the family physicians and the use of medication also continued. Of the three types of medication, she stated that clonazepam was the most helpful, both because it helped her sleep and because, according to her, it reduced her ‘tensions’ and ‘nervousness’. She evaluated the medical care she received as very good and stated that both her physician and the ‘matrix support’ psychiatrist always welcomed her, talked to her at length and gave advice and guidance for Diego’s care, which was sometimes better than what she received at the CAPS. In our last contact, she told us that, for the first time, Diego’s father had gone to talk with the CAPS psychologist, something she believed was important because she felt that the father needed to understand Diego’s problem better and to be more involved in his treatment.

‘Pedro’

Pedro was a tall seventy-three-year-old white man. Born in Chile, he had lived in Brazil for over forty years. He lived in an apartment in a middle-class building in one of the main streets of the ‘asphalt’. It was not a luxury building: it did not have a doorman, and the façade was old and worn. We were welcomed by Pedro and his wife, ‘Laura’, who was seventy years old and also Chilean. The couple were the only two residents of their apartment. When we asked what their biggest health complaints were, Pedro answered:

What worries me most is the debts that come every month and that I can’t pay entirely. My son helps me to pay them. This even affects food. Sometimes there’s not enough food in our home. The standard of living we used to have is totally different from the standard of living we have now. We could go out to eat every week, we could buy new clothes, gifts for our granddaughters on their birthdays, but we can’t now. All of this affects us, hurts us. Before, our granddaughters would come over on the weekend and the fridge would be full. Now, they don’t come any more, because the fridge is empty. It gives me anguish,
sadness, anger, and it makes me upset. I get up in the morning and to this day I’ll go take a shower thinking I’m going to work. But then it hits me.

Pedro was a retired engineer, but his income was not enough even to pay the rent. Until three years before our meeting, he had done freelance work for an important Brazilian state company. With the financial crisis that hit the state of Rio de Janeiro, these work opportunities disappeared and, even though he was retired, he found himself ‘unemployed’.

One of the effects of the financial crisis that caused most suffering for Pedro and his wife was the loss of contact with their granddaughters. Their only son was in a better financial situation and frequently helped them with their expenses. However, they had problems with their daughter-in-law, who ever since they had gone into debt had, according to them, distanced herself from them and made it difficult for them to contact their two granddaughters, aged five and seven.

Pedro attributed his sadness and anger to the fact that he was unable to get work. He then stated that he was even looking for ‘menial’ work. However, in addition to the difficulty caused by his age, he was unable to find employment opportunities because of the serious political and economic crisis that has affected the state of Rio de Janeiro and Brazil as a whole since 2014. He also complained of weight loss. He lifted his shirt and showed us his thin body, visible bones and caved-in abdomen, stating that he had never seen himself in this condition before. He stated that he slept well but, upon waking, remembered all of his problems. He did not believe he ate poorly and claimed his appetite was normal. Because of this, he did not agree that his ‘emotional state’ had produced the weight loss. He was worried about his wife because he believed she was more intensely affected by their family problems than he was. He was dedicated to caring for her, even bringing her breakfast in bed every day.

Pedro had started treatment at the family health facility around two years before we interviewed him and was satisfied with the care he received from his medical practitioner. In particular, he mentioned the free examinations he had been undergoing in order to monitor his diabetes, his hypertension and a benign polyp he had in his gallbladder, in addition to the medication distributed free of charge. He wished to have an endoscopy in order to rule out a stomach ailment as a cause of his weight loss. He did not establish a clear connection between his
weight loss and his ‘emotional state’. To him, the ‘emotional state’ was connected to his ‘finances’.

He was a chronic user of some other types of medication, in addition to those he used for his hypertension and diabetes. When he was ‘nervous’ and anguished, especially in the morning, he remembered his financial problems and took bromazepam, an anxiolytic tranquiliser, to calm down. He had always viewed himself as willing and happy to work, and he continued to feel this way. When asked whether he saw himself as having ‘depression’ or being depressed, he answered:

Depression is not wanting to do anything. I was reading on the Internet, it’s the person who doesn’t want to do anything, doesn’t want to shower, sleeps too much and has other symptoms. I don’t think I have depression. My emotional state is that of unemployment, I can’t pay what I owe.

In addition to his home visits, we followed two of Pedro’s consultations with his medical practitioner. After checking the results of his diabetes tests, which were stable, the physician would again ask Pedro how he was feeling and he would again state his sadness, his anger at his financial situation, his concern for his wife and his thoughts of ‘feeling like a nobody’, especially in the mornings. The Family Medicine physician explained that depression could present itself in ways other than a desire for isolation and a lack of interest in doing anything, and that antidepressants could relieve some of those symptoms, and could perhaps even make him feel more disposed to exercise and more inclined to eat a better diet, thus helping with his weight loss. Pedro had a routine check-up, which revealed that he had no issues besides the weight loss. During this appointment, Pedro agreed to begin taking the antidepressant fluoxetine. The physician then reinforced the suggestion that he take part in some of the ‘unit groups’ with his wife, and he answered that it was ‘a possibility’. He said he would try, but that the schedule offered was not very convenient.

Over the following months, Pedro continued to fail to gain weight, and he did not participate in any of the ‘unit groups’, but, after some resistance, started taking fluoxetine. However, he complained that he still saw no improvement with regard to his weight loss. He was still unhappy with his ‘unemployment’ and was worried about his wife. He kept regular appointments with his medical practitioner, who, in turn, insisted that he participate in the groups.
‘Hill’ and ‘asphalt’ as moral economies

Raquel and Pedro were patients considered to have depression by their Family Medicine physicians. However, the ethnographic snippets we have presented, except for the shared mentions of sadness, point to so many singularities that stating that these two people suffered from the same ‘mental disorder’ becomes, as Goldberg (2011: 226) noted, a form of ‘magical thinking’. Even sadness, mentioned by both, was experienced differently, and these differences could not be reduced to a variation in intensity. While for Raquel it was accompanied by suicidal impulses, for Pedro it was associated with anger and motivated him to want to keep on working. The bodily manifestations – the self-mutilation in Raquel’s case, and Pedro’s weight loss – were also different, pointing to distinct conceptions of corporeality. In both cases, the role of micro- and macro-social determination was so evident that it is difficult to frame the situation of these individuals in terms of mental illness alone or to regard their response to these circumstances as abnormal.

Some elements of their experiences corresponded in part to the illness profiles of the ‘hill’ and the ‘asphalt’ described by health professionals. In Raquil’s case, the violent interactions with her former partner, her mother’s unexpected death and her difficulties in accessing adequate care in the public health system for a son with a severe mental disorder caused her suffering. In Pedro’s case, social isolation, financial crisis and family problems accounted for his wife’s distress. However, certain important elements did not fit this categorisation.

Raquel experienced a certain degree of isolation within her community. She had expressed a desire to move because, living in the ‘hill’, she still interacted with people and places that reminded her of her previous relationship, which was marked by violent situations. In the three months during which we followed her, she would again have crises marked by suicidal thoughts, isolation and self-mutilation every three to four weeks, despite a care plan that involved continuous antidepressant use, frequent consultations with her Family Medicine physician and maintaining her jiu-jitsu practice and leisure activities with her family. At the end of the observation period, Raquel attributed an experienced improvement to starting individual psychotherapy.

Pedro did not match the profile of a ‘non-resilient’ man that was expected from an ‘asphalt’ resident. He was determined to work again,
if it were possible. Although experiencing low self-esteem, he reported that he was anxious to solve his financial difficulties, and did not feel sick or depressed. For this reason, he did not expect the ‘unit groups’ to help him with his problems, but he missed having a closer relationship with his daughter-in-law and granddaughters.

Experiences such as Raquel’s and Pedro’s illustrate an observation that was repeated, in different levels of intensity, with the twenty-two patients we followed more closely in the field. The classification of ‘hill’ and ‘asphalt’ that was incorporated into health professionals’ discourses and practices, as well as the interpretations and clinical approaches that derive from it, did not correspond to people’s experiences, and sometimes even diverged from them. On the Family Medicine physicians’ side, these divergent visions of suffering have repercussions, for example, in the evaluation of many ‘difficult’ cases in the ‘asphalt’ and in the recurring statement that patients in this area do not adhere to proposed treatments, especially those in the ‘unit groups’. On the patients’ side, there were accounts from ‘hill’ patients who felt that there was a lack of specialised mental health care; this was more frequently offered to ‘asphalt’ dwellers, who were sometimes regarded as ‘health insurance migrants’ and who at times did not establish good therapeutic bonds with Family Medicine physicians.

The moral dimension of the use of social categories such as ‘hill’ and ‘asphalt’ emerged as a fundamental question for an understanding of these different diagnostic and therapeutic approaches to depressive symptoms in these settings of public integral health care. For this analysis, we turn to Didier Fassin’s proposal of a critical moral anthropology as a perspective for analysing contemporary health policies (Fassin, 2008; Fassin, 2012a; Fassin, 2012b; Fassin and Rechtman, 2009), in other words, analysing how ‘hill’ and ‘asphalt’ work as ‘moral economies’, defined as ‘norms and values, sensibilities, and emotions’ that may be ‘rephrased as moral’, although they are not, in their usual sense, perceived to be ethical or moral (Fassin, 2012a: 4, 10).

Addressing the relationship between morals and politics, Fassin proposes that moral issues may not be understood in isolation from political, religious, economic and social spheres of human activity. One of the great enigmas in the social sciences is precisely that of the articulation between the macro-social (the different politics) and the micro-social (beliefs and practices), that is, understanding ‘how public discourses and public policies influence institutional and professional
practices – and are in return consolidated or sometimes reformulated through the latter’ (Fassin, 2012b).

In our field of study, the explanatory model of ‘lacking networks’ and lacking the capacity for ‘resilience’ in the face of social adversities produced moral and affective approximation or distancing between physicians and patients, depending on the different population profiles. The Family Medicine physicians presented discourses and practices that were aligned with the principles of the Brazilian public health system, especially equity and the interest in offering more medical care to neglected populations, such as the ‘hill’ inhabitants. Some of the professionals referenced the need to overcome the ‘inverse care law’. This concept was proposed in 1971 by the family physician Julian Tudor Hart, who, when analysing primary care access and therapeutic supply in south Wales, noted that the populations that least need care are the ones that have most access to health services, while the populations that most need care access these services the least (Tudor Hart, 1971; Chew-Graham et al., 2002).

The ‘hill’ represented a poorer population than that of the ‘asphalt’, less protected by social rights and policies. Nonetheless, these people were considered more resistant, with a greater sense of community and of the collective, values in tune physicians’ critical views of society. On the other hand, the ‘asphalt’ comprised a population with better social and economic starting points, but it was more individualistic, with few community practices and values, which made it more fragile, less resistant and less willing to accept care from family physicians. Thus family physicians’ social postures produced moral bonds with ‘hill’ patients – to whom they more frequently offered the psychosocial tools specific to their specialty, such as the ‘person-centred clinical method’ – and, on the other hand, a distancing from the ‘asphalt’ patients.

**Final thoughts**

In this ethnographic research, the use of the ‘hill’ and ‘asphalt’ categories as ‘moral economies’ has repercussions for physicians’ clinical practices and patients’ therapeutic experiences. The anthropological recognition and analysis of these practices provides new ways of looking at the complex social interactions that constitute the expansion of public mental health care in a Latin American metropolis such as Rio de Janeiro. It is not only ‘native’ medical categories, but also standardised diagnoses,
protocols and treatments that produce divergences between patients and health professionals in how depressive suffering is addressed.

The acknowledgement and use of social determinants in the interpretation of, and approach to, these experiences, exemplified in this research by the categories ‘hill’ and ‘asphalt’, may also produce these dissonances, especially when we analyse their repercussions in the affections that form the terrain of therapeutic social interactions. They may also create categories that encourage ‘one-size-fits-all’ approaches, the focus of concerns and debate in the Global Mental Health field, as we noted at the beginning of the chapter. Sociocultural categorisations may become obstacles to more singularised evaluations of suffering, even though they are often created with the intention of producing an integral, ‘bio-psychosocial’ approach, as in this case study.

Therefore in this scenario, a relevant social research task is to show the role that social procedures such as the ‘hill’/‘asphalt’ categorisation and its moral dimension have in the recognition and treatment of emotional suffering. The offer of, and justification for, biomedical resources such as psychiatric diagnoses and pharmacological treatments, and also psychosocial interventions such as ‘groups’ and ‘person-centred consultations’, were moulded by this categorisation. In this ethnographic study, we understand that making the adoption of these categories and their repercussions visible may be a useful resource for reducing barriers to understanding between health care users and professionals regarding the former’s experiences of mental suffering and the latter’s therapeutic practices. An important challenge for urban mental health is exploring how our experiences of the city and the environment are an important component of the construction of subjectivity, in its reflexive and emotional aspects. In a territorially ‘broken’ city such as Rio de Janeiro, ethnographic health research may point out paths to deconstructing often invisible social, health and moral barriers, unravelling their production processes and thus signalling the possibility of critical (re)constructions and moral proposals that, at least, reduce the weight and rigidity of social division mechanisms and the categories that derive from them.

Notes

1 There is no dataset for Rio de Janeiro comparable to the São Paulo Megacity Mental Health Survey, a population-based survey funded by WHO. The existing studies in Rio are not population-based but composed of smaller samples,
mostly from primary care services (Fortes., Villano and Lopes, 2008; Fortes et al., 2011; Gonçalves et al., 2014).

2 Over the years, part of Rio’s low-income population has settled on the city’s hills, forming the favelas. The city’s high-income citizens usually live by the sea and in elegant planned neighbourhoods and gated communities – referred to locally as the ‘asphalt’ – in contrast to the hills, where urban development has little in the way of formal planning and often lacks proper infrastructure.

3 The ‘matrix support’ team is the Brazilian model of collaborative care in mental health within the primary care system. It involves multiprofessional teams that may include psychiatrists and psychologists. They offer ‘matrix support’ – a concept of work process integration in health care, developed and used in the Brazilian FHS – to assist primary care teams (Wenceslau and Ortega, 2015; Athié et al., 2016). In practice, psychiatrists consult together with the Family Medicine residents, when required by the latter. They also discuss diagnostic and treatment options with the residents.

4 CAPS are community mental health care centres that replaced psychiatric asylums following the Brazilian psychiatric reform.

References


Urban transformations and public health


Lopes, C.S., Hellwig, N., de Azevedo e Silva, G., and Menezes, P.R. (2016). Inequities in access to depression treatment: Results of the Brazilian
Urban transformations and public health


Urban mental health


WHO (2016). mhGAP intervention guide for mental, neurological and substance
Urban transformations and public health


