

LATIN-AMERICAN PERSPECTIVES ON GLOBALIZATION AND MENTAL HEALTH

Renato D. Alarcón
Marina J. Piazza

Introduction

There is arguably no period in history which may have not been considered stormy, uncertain, difficult, and dangerous by those who lived through it, by the chroniclers that reported on its avatars, or even by the scholars that decades or centuries later committed themselves to the task of analyzing them. The ingredients of anguish, doubt, ambivalence, or even a self-convincing notion that never before the situation was more tragic, are common features of this perspective. Obviously, the opening decade of the 21st century is no exception, and in the so-called Third World, this conviction is even more dramatic. Latin America, as part of such immense geo-economic segment, has its share of rampant poverty, domestic, criminal, or political violence, oppression and terror, hand in hand with social and cultural inequities, malnutrition and infections, AIDS, and a dearth of accessible and capable health services. It is, therefore, imperative to discuss these realities keeping in mind the context and the meaning of a phenomenon that would be dangerous to ignore: globalization. This article attempts to examine the realities of mental health in today's Latin America, the political, social, cultural, and ethical nature of such realities, as well as the options to improve them both quantitatively as well as qualitatively (Frenk and Gómez-Dantés, 2002).

Globalization: Concepts and Implications

The first irony in this analysis is that the term is defined and understood differently by economists, social communicators, scientists, and the public at large (Watkins, 2003). Economists and politicians, particularly those of the so-called developed world, view globalization as the evolvement of immense opportunities of economic growth and concomitant possibilities of greater incomes for individuals, families, nations, continents, or regions across the world (Sachs and Warner, 1995; Beim and Calomiris, 2001 &

Stiglitz, 2002). For social communicators or even social scientists, globalization reflects primarily access and dissemination of information in a precise, immediate, and objective fashion. The “global village” is a favorite metaphor of these perspectives (Atasoy, 2003; Martin, 2001 & Castells, 2000).

Others see globalization as little less than the greatest and most sophisticated contraband of ideas experienced by mankind throughout all its history. Greater income, yes, so they say, but for the wealthiest industrialized countries or, even worse, for its corporations, consortia, and conglomerates. More jobs, yes, but with inferior salaries and without greater benefits in the middle and long-term. More access to communication, yes, but only for the dissemination of subcultures and lifestyles that are alienating vehicles of mediocrity and undesirable homogenization. More information, yes, but information that is manipulated and disguised, aimed only at exacerbating a vacuous consumerism, those “greater incomes” devoted to the frivolous acquisition of frivolous items (Saul, 2004). The benefits for health and education, important in every design of social and economic development are eminently collateral results of a process that is totally predictable according to globalization’s advocates. For its critics, however, the world may very well be a village or even a city, but like any other, it still has the *barrios*, ghettos, or *favelas*, growing aggressively next door to its residential, exclusive, aseptic and super-elegant sections.

The determining factors of globalization are manifold. The history of civilizations has always known of groups and collectivities whose aim was the conquest of more land and the subjugation of more people. Migration, first from east to west, and now from south to north and across the globe is perhaps the most dramatic sign of globalization (Martin, 2001; Simmons, 2002 & Center for Immigration Studies, 2005). Contemporary economy grows supported by practices such as outsourcing, “cheap labor,” migrant workers and transcontinental computers. Science and technology are the main mechanical weapons of globalization. Communications represent a potential higher level of information and education, not always realized. Finally, culture is a determinant of globalization through processes such as hybridization, *mestizaje*, or interactions of groups and populations that result in dramatic – and disconcerting – change of identities (Ward and Styles, 2003; Hochberg, 2004; Liang and Krieger, 2004 & Arnett, 2002). This, of course, should be managed in a humane and ethical manner (Marmora, 1998). The critical perspective about globalization is

supported by dramatic statistics. Mike Davis, a social commentator, wrote in 2004:

Sometime in the next year, a woman will give birth in the Lagos slum of Ajegunle, a young man will flee his village in west Java for the bright lights of Jakarta, or a farmer will move his impoverished family into one of Lima's innumerable *pueblos jóvenes*. The exact event is unimportant, and it will pass entirely unnoticed. Nonetheless, it will constitute a watershed in human history. For the first time, the urban population of the earth will outnumber the rural.

In 1950, there were 86 cities in the world with more than one million inhabitants; today there are 386, and in the year 2015, there will be at least 550, more than 100 in Latin America (Gilbert, 2004). Only the urban population at the present moment (about 3 billion) is much larger than the total world population in 1960. Rural areas will reach their highest population across the world (3.3 billion) in 2020, and only then they will start to decline. As a consequence, the world population of the future -whose peak of 9 billion is expected for 2050, with more than 780 to 800 million in Latin America, 221 of which will live in Brazil, 150 in Mexico, and 53 in Argentina- will be crowded primarily in the cities, as Davis has predicted. What is worse, 95 percent of this number will live in the urban areas of developing countries, whose population then will double to near 4 billion in the next generation. In the year 2001, 924 million people were living in poor slums of the cities, and at least half of this population was younger than 25 years of age. The most dramatic result of this process will be the multiplication of mega-cities (with populations in excess of 8 million), at least 18 in our continent and, even more dramatically, the increasing numbers of "hyper-cities" with more than 20 million inhabitants. In Latin America, Mexico City, São Paulo, and Buenos Aires, will be hyper-cities (Hyman et al., 2004).

Advocates of globalization like Stiglitz (2002), believe that by removing barriers to free trade, and making possible a closer integration of national economies, globalization...

"can be a force for good, and has the potential to enrich everyone in the world, particularly the poor" (p-IX).

These optimistic views are echoed by Feachem (2001) who claims that...

"openness to trade, to ideas, to investment, to people, and to culture, brings benefits today as it has for centuries—and it

also brings risks and adverse consequences, as it has for centuries”.

Okasha (2005) affirms that the...

“global village allegedly created by globalization is not that global after all”.

Of 100 people living on Earth, 57 are Asians, 21 are Europeans, 8 are Africans, 6 are Americans. Forty-eight are men, and 52 are women; 30 are white, and 70 are non-white; 30 are Christians, and 70 are non-Christians. On the other hand, 6 people own 59 percent of any community’s wealth, and they are all North American. Eighty out of 100 live in poverty, 70 cannot read, 50 die in famine, one has a higher education, and one has a computer. It is obvious that power and resources do not seem to follow the majority/minority pattern of the world population; this means that globalization has failed to represent democratically the world it has claimed to globalize.

Social, intellectual, and scientific leaders in Latin America agree with advocates and adversaries of globalization in one point: the process is inevitable and unstoppable. Technological advances and resources devoted to mass communication in many countries are catalyzing this phenomenon. The main questions are how and what shape globalization will adopt, and how long will it take. Globalization is in the minds and documents of working groups of international organizations, national governments, or boards of directors of corporations and financial entities (Brundtland, 2005; Waitzkin et al., 2005). Even though it is inappropriate to speak of “equal distribution of wealth” when 80 percent of the world population is malnourished and without access to health services, when similar numbers live in sub-human conditions subject to the threats of disease and disasters, or when more than half of the workforce in the world has an income below the poverty level of developed countries, it is clear that globalization will occur (Cattell, 2001). In fact, it is already occurring (Brown et al., 2006).

Globalization and Mental Health

Globalization in psychiatry and mental health has not produced a cohesive and integrated picture of human function and dysfunction, strengths, and vulnerabilities, despite the prodigious advances in many areas. One reason, according to Berger and Luckmann (1967), is the appropriation of terms (i.e., self) by psychology and related disciplines to constitute a positivistic

language that has become more and more complicated, almost in the manner of a unique, sometimes untranslatable dialect. Westernized scientific language has isolated its disciplines in such a way that communication across cultures in a globalized world, may be interfered with in spite of the accessibility of technological advances. The perpetuation of pseudoscientific treatments without much empirical support, may indirectly contribute to the flourishing of charlatanism and forms of shamanism that despite that lack of scientific evidence may feel and act closer to the realities of the common man's suffering. An alternative is the use of a common language, one that may help to transcend the gulf created by an unidirectional globalization, by rescuing descriptions of perceptions, behaviors, attitudes, and systems that will be truly holistic, candid as well as constructive. Even the internal dilemma of "mind versus body" can move away if they are seen as hybrid realities, consequences of our physicality as well as our immateriality (Rizzolatti & Fadiga, 1998).

Globalization and psychiatry/mental health must strengthen an interdisciplinary approach through the use of multicultural dialogues, culture understood not only in terms of ethnic, socioeconomic, or geographic basis, but in terms of the everyday actions of systems, entities, and organizations leading knowledge and practice in public mental health. Miller (2006) summarizes the "mental illness's global toll" in terms of a growing burden of neglect, family erosion, and developmental handicaps, with even stronger consequences in terms of the relationship of human groups with amorphous health systems in developing countries.

Against this background, the global picture of mental health is one of the greatest and perhaps most ignored (although, fairly speaking, this is changing) problems in the contemporary world. The impact of all these factors on health, and on mental health in particular is perceived not only in terms of growing prevalence and incidence, a change in diagnostic and therapeutic practices, provision of services and public health policies and research (Dech et al; 2003). It also shows in areas that include stigmatization, prejudice, discrimination, and the dramatic fracture of decent human relations. The area of human rights has a direct link with globalization and its impact on mental health (Jakubec, 2004).

The prevalence of mental disorders is increasing both in urban and rural sections. World Health Organization's estimates place at least six mental disorders or related conditions among the top 10 of those with the highest impact on the workforce, economic

productivity, and quality of life across populations (Murray and López, 1996). The evident link between poverty and mental disorders is undeniable, with poor education, poor income, poor sanitary conditions, low level of education and health information, and the interference of some (not all) cultural beliefs and practices making globalization an even more alarming and quite serious threat for this and forthcoming generations (Dejarlais et al., 1995; Lacroix and Shragge, 2004).

Mental Health Realities in Latin America

The current population of Latin American and Caribbean countries is close to 500 million people. The per capita average income reaches \$12,000 per year. Former peasants and their families, impoverished and separated from their social networks, find in many cases that the new urban context does not provide opportunities to recreate their cultural traditions and norms in an adaptive way. Living in the “belts of misery” around the big cities, they become both a source and a target of violence, a setting of emotional and material losses in a daily perpetuating pattern, with the subsequent harboring of resentment, anger, and more violence (Alarcón, 2002). About half a million physicians across the continent include no more than 15,000 psychiatrists making a ratio of 3.4 psychiatrists per 100,000 inhabitants.

Mental health, as a branch of public health has a relatively young history in Latin America. It is fair to say that, recently, the attention paid to mental health in developing countries in general, and in Latin American countries in particular, has increased. A number of issues, including the high prevalence of mental illness in the general populations as well as in primary care settings, are gaining increasing relevance. Other topics include the emergence of new mental health needs, and their association with social and cultural processes such as violence, disasters, internal and external migration as well as wars and forced displacement, generate increasing disability levels related to mental disorders.

The prevalence of mental health problems has been estimated in 18-25 percent in the community at large, 27-48 percent in clinical settings, and about 12-29 percent among children and adolescents. The population affected by these problems reached 20 million in 1990, and it will be about 35 million in 2010. Among the most frequent and dangerous disorders, depression, anxiety, and somatoform problems represent about 20 percent of the total prevalence. Epilepsy, with 5 million (of which only 1.5

receive adequate treatment), and schizophrenia, from 3.3 to 5.5 million, are part of the daily drama in Latin American streets, slums, and homes. The phenomenon of “social exclusion” has been described -the abandonment of the mentally ill by families that cannot simply take care of increasingly deteriorating clinical conditions when the primary needs of the group remain unattended- (Alarcón, 2002; Pan American Health Organization, 1990 & World Health Organization, 2001).

The economic costs in terms of disability adjusted life years (DALY), reaches 7.1 to 11.5 percent in Latin America. Additional burdens are the impact of mental illness on families and caretakers, the occurrence of physical problems, stigma, and human rights violations. Sixty percent of cases of psychoses go into chronicity, thus putting added pressure on deficient and insufficient mental health facilities - inpatient, outpatient, and community. About 10 percent of psychotic patients in a Brazilian study had not received treatment, and 30 percent of them remained in chronic hospitals or asylums (Leitao, 2001).

Mental health in Latin American countries takes less than 1 percent of national health budgets, with very few exceptions. Nevertheless, there are some encouraging figures regarding mental health policies, programs, and legislation: after 1990, 65 percent of the countries have specific mental health policies, 81 percent have mental health plans and programs in operation, and 58 percent have specific mental health legislation. The workforce per 100,000 inhabitants includes 3.4 psychiatrists, 1.7 psychiatric nurses, 2.8 psychologists, and 1.9 social workers. There are 3.3 psychiatric beds per 10,000 inhabitants, 47.6% of which are in psychiatric hospitals, 16.8% in general hospitals, and 35.6 in the community. More than 70 percent of Latin American countries have less than 20 percent of psychiatric beds in general hospitals. Only three countries have more than 50 percent in general hospitals and residential settings, and only 30 percent have community services. As mentioned above, there are limited psychosocial rehabilitation services (World Health Organization, 2001a).

Eighty-seven percent of Latin American countries have policies regarding the use of psychotropic medications, but more than 1/3 have insufficient supply in psychiatric hospitals and primary care clinics. The cost of basic medications is low, but even that may not be affordable by significant segments of the Latin American population. Resorting to pharmacists, amateur healers, *curanderos* and shamans adds to the risks involved. Existing

workforce resources are concentrated primarily in metropolitan areas. Like in other parts of the world, primary care physicians, non-psychiatrists and non-physician personnel may be the first line of contact for patients and families in need. Fields that are dramatically scarce in resources include child psychiatry, geriatric psychiatry, addictions, and forensic psychiatry (Pan American Health Organization 2001, 2001a, 2001b; Alarcón & Aguilar-Gaxiola, 2000).

There are relatively few training programs, a number of which are not well regulated in terms of personnel, structure, duration, curricular content, quality assessment, and quality outcomes. It is a reality that vocations for psychiatric and other mental health professions oscillate throughout the years setting up the stage for a chronic lack of adequate numbers of professionals. A number of young professionals leave their countries towards North America or Europe in search of better training; this “brain drain” results in at least one-half of those “migrant health workers” never returning to their countries of origin.

Knowledge of the impact of social determinants on mental health opens up opportunities for the design, implementation, and evaluation of preventive and therapeutic interventions (Alarcón & Aguilar-Gaxiola, 2000). This includes taking advantage of the enhanced roles of family members and communities as resources in the provision of care. Principles of health promotion and health prevention, population-focused, ecological models emphasizing social determinants, epidemiologically-based programs, and application of principles of social justice, equity, empowerment, and participation are well known in professional and academic circles (Huynen et al., 2005). The implementation of these programs is challenged by a pervasive lack of financial, material, and human resources, mediocre bureaucratic structures and regulations, lack of political will and commitment and, last but not least, a level of misinformation and concomitant indifference on the side of the community as a whole. These realities are changing, however, on the basis of increasing numbers of nongovernmental organizations, lay groups, family groups, and entities, as well as the increasing presence of social advocates, and even of public figures or “celebrities” doing in Latin America what their counterparts in the Northern hemisphere have been doing for years, contributing to the de-stigmatization of mental illness and its consequences.

In the last 35 years, a number of experiences in mental health care, prevention, and promotion in several countries enhance this hope. These experiences in: Honduras, Brazil, Columbia,

Venezuela, Argentina, Mexico, Cuba, Chile, Bolivia, and Perú (Alarcón, 2002; Murray & Frenk, 2000) have resulted in increased community psychiatry work in marginal neighborhoods, ambulatory primary care and community health promotion, mental health training of primary healthcare workers, community-university-state collaboration for expanded coverage and education, increased support from the public, establishment of social networks, systematization and dissemination of training materials for the development of preventive interventions, programs for victims of domestic violence and drug abuse, and enhancement of interpersonal skills.

Annual investment per capita in science and technology is about \$60 in Brazil and \$20 in Mexico compared to \$900 in the US. Research has shown limited progress, but there are, once again, encouraging signs. Only 2.2 percent of more than 8000 publications in 15 international psychopharmacology journals come from Latin America. Brazil, Argentina, Mexico, and Chile are consistently ahead in funding, publications, and citations. There are mental health centers or institutes, mostly devoted to research in Mexico, Colombia, Brazil, Chile, Costa Rica, Argentina, Perú, and Jamaica.

The area of ethics and human rights has reached significant levels of prominence in Latin America. Ethics, in terms of protection of human dignity, an essential human right, is growing, thanks to the action of specialized offices of international organizations established in individual countries and with supervisory, monetary, advocacy, and educational impact across the region. There is increasing interest in consolidating some gains, but a lot remains to be done (Lolas, 2005).

Globalization and Mental Health in Latin America

According to Kirmayer and Minas (2000), psychiatry across the world will be impacted by the globalizing process through its influence on the unfolding of individual and collective identities examined above, its effects on economic inequalities on the practice, access, and actual provision of mental health services, and also in terms of the “shaping and dissemination of psychiatric knowledge itself” (Kirmayer, 2006). Mastrogianni and Bhugra (2003) reflect also on issues such as social class, unemployment, poverty, and poor housing which, by affecting mental health, should or could also be targets of a progressive globalization. The removal of these barriers, perhaps together with a rational medicalization of some psychiatric symptoms, may have a

favorable impact.

Diagnosis and changes in the way symptoms are identified, help is sought, treatment dispensed, and clinical course assessed can also be impacted by globalization. The interactions between individuals and their social and economic environment are likely to become more complex, and perhaps less clear. The challenge to researchers by issues related to migration and subsequent demographic changes, employment and productivity, and cultural mixing as a result of globalization, will be strong. The ethical rules will change when the congregation of different cultures in metropolitan areas makes definitions, territoriality, coexistence, or urban warfare alternatives that can no longer be postponed. The delineation of life in common and resource-sharing between cultures will have an enormous impact on the mental health of these new collectivities.

A Latin American perspective on globalization, psychiatry, and mental health encompasses a number of issues. The following section addresses some of them.

Theory and Practice of Public Health and Mental Health

The emerging demands of the economic, political, and social contexts of Latin American countries make it necessary to have a common political agenda of three topics: changes in the conceptualization of teleological and operative domains; examination of the collective health movement in a truly transdisciplinary knowledge and universalization of practice; and articulation of the social transformation of health with new scientific paradigms capable of approaching the health-disease-care objective with new approaches to historicity and complexity (Paim & Almeida-Filho, 1998).

Informatics

Telecommunications will transcend institutional, organizational, and cultural boundaries. In the context of mental health care, this means that the information, inquiries, and demands on service provision can be routed anywhere, free of institutional or other types of control. Organizationally-initiated applications such as telemedicine and telepsychiatry are usually intended to reinforce local systems, but their very design and intention may lead to a potentially rapid transcending of inherited but electronically ineffectual boundaries. The consequence of such uncontrolled

globalization of healthcare activities will range from beneficial empowerment and quality improvement to detrimental effects such as overloading of experts, undermining of stable healthcare systems (Rigbi et al., 2000), and erosion of privacy. A major unplanned societal re-engineering effect in a so far paper-based culture is likely to be significant, so the institutions of the future need to respond by creating positive global informatics frameworks and policies. Latin America, as an important component of that new global frame, will have to make sure that issues of language, idioms of distress, help-seeking patterns, and other service-based qualifications should be adequately explored (Kleinman, 1985 & Errington, 2004).

Multidimensionality and Multidisciplinarity

This is an essential component of any globalized effort. Against the paradox that globalization may accentuate specialization; the realities of 80 percent of the world community imply that a multidimensional, broad knowledge, generalistic approach to health and mental health will still have a place in the future. The risks of this approach include isolationism and alienation, artificial but powerful barriers being erected to prevent true, genuine, and open communication. It is not only the issue of new languages or different languages but also different practices, in short, the generation of new cultures. If the porosity necessary to enhance communication is not accomplished, the negative results will be immense. Multidisciplinarity, based on mutually respectful approaches from different fields of knowledge and practice, and on the provision of settings in which the dialogue can be practiced and the decisions that result from it, adequately implemented, should be essential ingredients of the future globalized mental health (Hinton, 1998).

Expansion of Services

It has been said for decades that primary care would be a “natural ally” of mental health in the provision of services. Patients come to the primary care practitioner or primary care clinic first, long before a referral to a mental health setting or provider is made. In Latin America, as in other parts of the world, the results of this process are mixed. On the one hand, while primary care offers an opportunity for more immediate therapeutic or even social interventions by different members of a multidisciplinary

mental health team, it is also true that overwhelming the system may result in shorter, customary, or more mediocre, type of services. Furthermore, primary care practitioners (not only physicians) may not necessarily give mental health issues the preference or relevance that they deserve in the urgent, fast-paced scenario of their work. In this context, the globalization of mental health should pay attention, once more, to the structuring of teams where the information flows easily, with active participation of different disciplines to support and advise the primary care practitioner. Rapid interventions (particularly when they have a preventive seal) can make these actions more effective. Primary care will continue to be an ally of mental health in the globalized provision of services, but it has to be a process of continuous self-search and self-evaluation.

The Five A's of Global Mental Health

Known in the daily jargon of community health and mental health fields for several decades, the five A's have a rare resilience both conceptually and pragmatically, thus offering consistency in any approach to these areas across the globe (Borus et al., 1979). The first A, availability, simply indicates the existence of services no matter what their structure, the very fact that they are not just theoretical topics or items in legislation, but an active presence in the field. The second A, accessibility, represents one step further: the services are not only there, but they are reachable, be that in the physical/geographical distance sense, but also in terms of a genuinely human level of contact. The third A, affordability, is crucial considering the social and particularly economic implications of the provision of services in communities small and large across the world. That the population must have the possibilities to either pay for services, or being assisted in the payment of those services, is crucial for an authentically humanistic care. The fourth A, applicability, speaks to the issue of actual correlation between what the problem is and what the intervention offers. It is a matter of fitting the needs with the services, not to offer opulent, expensive procedures to populations that cannot benefit from them, nor using the wrong equipment in and for specific clinical conditions. The fifth and last A, accountability, has to do with an indispensable need for checks and balances, objective assessment of efficiency and effectiveness, measurement of benefits versus risks, and actual gains for the "human capital" (Cattell, 2001).

Latin American Contributions to a Global Psychiatry

In the conceptual area, Latin American psychiatry's main contributions to a globalized discipline are its genuine acceptance of advances from other latitudes, a healthy *mestizaje* (that is not simply a new form of eclecticism), the social background of its main concerns, and a critical but constructive attitude towards other forms of thinking and doing, will have a positive impact. Similarly, a genuine humanism, the one that goes beyond rhetoric to become an actual practice of new principles based on solid knowledge, evident by itself, by everyday practice, by consensus, and by the consideration of human dignity as an essential component of the encounter between practitioner and patient, is a unique piece in the edifice of Latin American psychiatry (Alarcón, 2004; 2006). Rosen's (2006) suggestions on what developed countries can learn from developing countries, at macro-(inclusiveness, acceptance, reintegration, networking and learning through experience) and micro-levels (holistic appraisals, therapeutic optimism, family and community engagement) are extremely pertinent.

The contributions in the area of cultural psychiatry, not only in terms of culture-bound syndromes, but in terms of an understanding of how technical, scientifically-based disciplines can interact with popular wisdom, centuries of accumulated knowledge in traditional medicine, the use of herbs, as much as the use of charismatic perceptions and their impact on emotional conflicts are areas in which Latin American psychiatry has excelled (Seguin, 1974 & Alarcón, 2003, 2005). Even in the more "scientific" (from the Western perspective) areas of psychopathology and epidemiology, Latin American psychiatry should and will attempt to rescue the values of a good descriptive, objective, humane, comprehensive, and integral approach to the suffering of fellow human beings.

That the identity of Latin American Psychiatry is still a work in progress (Alarcón, 2001), does not minimize its extraordinary accomplishments. The fields of epidemiology, phenomenology, social psychiatry (including community and folkloric psychiatry), clinical research, and psychiatric epidemiology have seen enormously valuable contributions by Latin American psychiatrists. In recent decades, work and research groups in several countries have advanced the knowledge and the practice of areas such as psychotherapy and clinical psychopharmacology. More recently, contributions to clinical genetics, and renewed reports in the field

of epidemiology have emphasized teamwork, international collaboration, and broadening of scopes that certainly will contribute to a more concrete and favorable linkage with psychiatry in the rest of the world (Alarcón, 2003).

By the same token, trying to define the identity of Latin American psychiatry does not mean separation, isolation, or search of a fragile uniqueness, blocking a necessary dialogue with the rest of the psychiatric world. Latin American psychiatry does not want to, and must not be, a stranger in the mythic “global village” of the future that is now with us. On the contrary, it wants and must have credentials that will allow its access to world psychiatry guaranteeing respect and acceptance. Latin American psychiatry shares fully the nuclear core of knowledge and practice known in the entire globe, accepts contributions from abroad in the name of a healthy universalism and of a constructive mestizaje leading to the sharing of accomplishments and experiences with the rest of the world. Knowing who we are is an antidote against alienation, but also against imitation; it is a card of independence and a bastion against subordination; it represents confidence in our own means and is, on the other hand, the best preventive agent against xenophobia (Alarcón, 2004 & Hoshmand, 2003).

Conclusions

Latin America and Latin American psychiatry and mental health can, and should be part of a globalization that implies genuine commitment to social justice, ethical management of policies and services, and equal access to service and communication. Latin America has the advantages of its geographic closeness to the only super power in the world, as well as the realities of undeniable social, economic, and political differences. The cultural basis of these distinctions are obvious, and should be taken into active consideration when dealing with the issues of globalization.

The contributions of Latin American psychiatry are based on the accurate examination of its history, its identity, its epistemological as well as pragmatic development over decades. Its participation in the new global conceptualization of mental health should be the result of an adequate examination of problems, needs, responses, and options that keep into account the fact that we are no longer alone. In this context, a rational use of technology, adequate distribution of resources, combination of efforts with areas such as primary care, adequate and balanced

dissemination of knowledge, acquisition of new knowledge, as well as a realistic utilization of its advances, can create a possibility of success (Yach, 1997).

In the interminable debate between science and humanism, convergence should be the goal, finding ways through new visions of humanism, phenomenology, psychopathology, diagnosis, and treatment to make sure that all the dimensions of the unique human encounter between patient and practitioner are comprehensively covered. Classic psychopathology may be now enriched by neuroscientific, biological, as well as anthropological and social contributions. It is the work of psychiatry and psychiatrists of the future to provide a genuine, solid explanatory pluralism to mental illnesses and their management, much in the way advocated by Kendler (2005).

The never-to-be forgotten subjective dimension has, in the battles of global psychiatry, a place of extraordinary importance (Savin and Martínez, 2006 & Krause, 2006). It has certainly links with the humanistic approach mentioned above, but also in recognizing the “ownership” of experiences that are unique and personal. The neurobiological, electrophysiological, biochemical, pharmacological, and physiological basis of phenomena such as decision making, consciousness, “the unconscious,” the acquisition and practice of what we call values, or even primitive emotions such as sinfulness, violence, or impulsivity do have a precious subjective dimension whose implications and imbrications remain to be explored.

Last but not least, the ethical dimension, at this point in the 21st century, will try to combine traditional humanism with the newly arising environmental ethics based on communitarian ways of thinking. According to Sakamoto (2005), this does not always mean that the new global bioethics is necessarily universalistic for we should stand on the recognition of the widespread variety of value systems in the world, north and south, east and west. However, it is not particularistic either, for in order to establish a post-modern global ethics, we have to accept and harmonize every kind of antagonistic values in this world. The cultivation of a new social technology, tuning social disorder of not only international but also interethnic and intercultural levels of ideology beyond traditional humanism, will strengthen the significance of human rights or “human dignity” now and in the future (Bloch and Pargiter, 2002). Latin America is also the most appropriate field for the development of this new, genuinely globalized and human ethics.

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ABOUT THE AUTHORS

Renato D. Alarcón, MD, MPH. Professor of Psychiatry, Mayo Clinic College of Medicine, and Medical Director, Mood Disorders Unit, Mayo Psychiatry and Psychology Treatment Center, Rochester, Minnesota, USA. Born in Arequipa, Perú, graduated from Cayetano Heredia Peruvian University in Lima, did his Residency Training at Johns Hopkins Hospital, and obtained his MPH degree from Johns Hopkins University, School of Public Health. Corresponding Member of the National Academy of Medicine in Perú. Author of more than 200 papers, 12 books (including *Identidad de la Psiquiatría Latinoamericana*, *Los mosaicos de la esperanza*, *Texto Latinoamericano de Psiquiatría y Enciclopedia Iberoamericana de Psiquiatría*), and book chapters on mental health and public health, cultural psychiatry, psychiatric diagnosis and clinical research.

Marina Julia Piazza-Ferrand, DSc, MPH. Professor of Public Health, Cayetano Heredia Peruvian University, and Director of a Fogarty-NIDA funded International Program, in cooperation with Michigan State University. MPH and Doctor of Science degrees from Johns Hopkins University School of Public Health. Hubert Humphrey Fellow at Hopkins, additional post-doctoral studies at the Center for Adolescent Health Promotion and Disease Prevention in Baltimore, Maryland, USA. Principal Investigator for WHO’s Gender, Alcohol and Culture Study (GENACIS) in Perú, currently developing the National Surveillance System in Drug Demand, for the National Commission for Drug-free Life and Development.