Medicalizing Suffering:
Postsocialist Reforms of the Mental Health System in Ukraine

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Shelly Ann Yankovskyy
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Dedication

Нина Фёдоровна Зель (1918 - 2013)

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Abstract

This dissertation explores how mental health reforms in postsocialist Ukraine, specifically the push for privatized community mental health services, are playing out on the ground through provider and patient perspectives and are mediated by nongovernmental organizations (NGOs). I argue that the international agenda promoted in Ukraine that pushes for western neoliberal political and economic reforms has produced cultural and structural discrepancies and tensions which can be seen in the mental health field. As major reforms are promoted, including the shift from state hospitals to private "community-based" services as part of a transition from socialized to privatized or insurance-based care, and as providers adopt the U.S. – modeled International Classification of Diseases [ICD-10] to diagnose and treat mental health disorders, the cultural meanings of socialism and capitalism collide and coalesce around questions such as where (or with whom) the responsibility for health lies, the proper relationship between psychiatrists and patients, and the prioritization of the individual vs. the collective, and the implications of these. Amid these cultural and structural changes, moreover, the neoliberal agenda forces Ukrainians to replace deeply rooted cultural tenants shaped by socialism with those of U.S. dominated corporate capitalism. Human rights discourse has been adopted by some NGOs as a way to mediate and critique these processes of cultural change induced by transformations in political economy. I use psychiatry and mental health as a window into this struggle.

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Introduction

In November 1989, a world divided into the communist East and capitalist West watched in awe as the Berlin Wall, that iconic image of the Cold War, crumbled to the ground. I was among those watching, but at such a young age and still in middle school, I lacked the capacity or experience to even begin to understand what this event meant or how the world was changing. Looking back, I think many people in the West felt relieved and that maybe now the world would be safe for capitalism, free markets and democracy. In the East, and particularly in Ukraine, there were cries for independence and a renewed sense of nationalism mixed with a sense of fear about the future.

Yurchak (2006:2) writes that many in the Soviet Union experienced a sudden "break in consciousness," or a "stunning shock," followed by "excitement and readiness to participate in the transformation." In 1991, the end of the Soviet Union and independence for republics, including Ukraine, was finally realized and the world sat in anticipation of the "transition" away from socialism that was supposed to ensue. Verdery (1991:419) described the collapse of Communist Party Rule as a "new phenomenon for social scientists to flock to: the transition from socialism, or at least from its hitherto institutionalized Marxist-Leninist variant."

This transition from socialism, or "postsocialism," however, reflects much more than the transition of former Soviet countries away from socialism, it is "the condition of the world in the aftermath of a global cold war that derogated socialism and laid the groundwork for cultural dispossession" (Koch citing Creed 2013:26-27). The Soviet Union ruled much of Eastern Europe for seventy years; well documented now is the

"tremendous suffering, repression, fear, and lack of freedom" (Yurchak 2006:8) it produced. This is not the entire story, however. As Yurchak (2006:8) suggests there were internal paradoxes and for many socialism was not necessarily equivalent to "the state" or "ideology," but was experienced and understood quite differently than official interpretations.

In my own research on mental health reforms in postsocialist Ukraine I have tried to adopt a broad conceptualization of "transition" in order to avoid the "binary metaphors" that are so widespread in the analysis of socialism and transition (Yurchak 2006:6) and instead explore the nuances, contradictions, and tensions that have ensued as a result of changing political-economic systems. For example, Ukraine is no longer a "socialist" society, but it is also not a "neoliberal" society either, as elements of the Soviet system are still at work. Moreover socialism and neoliberalism as total systems are quite similar in that they shape and conceptualize health and illness, as well as personhood, in particular ways. I argue that both subordinate individual needs to the larger goals of the system and elites who control it through their common project of consolidating hegemony although through different ideologies and practices. The Soviet system tended to demonize the individual, while the neoliberal celebrates the individual; however in both systems the objective is to promote a particular totalizing vision, and the concept of the individual is manipulated to serve this goal. As I show throughout this dissertation, both systems have utilized biomedicine to medicalize suffering, defining social and physical problems as medical in nature and using medicine as forms of social control (Singer and Baer 2007:92). Both place the responsibility for illness on the

individual and in so doing divert attention away from the structural dimensions of suffering. Under both systems, biomedicine, discourses of science, and particular ideological constructions of the individual and his or her relationship to the state and society were utilized to legitimize the political-economic arrangement. In this way, socialism and neoliberalism are not so different; the transitions taking place in Ukraine highlight the tensions inherent in both systems and contain overlapping elements.

Mental Health Care Reform in Postsocialist Ukraine

A complete transformation of the healthcare system is currently underway in Ukraine, including the mental health system. Thus far, the major focus of mental health care reform for Ukrainian policymakers is evident in three areas: the transition from "institutional" to "community-based treatment;" the transition from socialized to privatized or insurance-based care; and the adoption of the U.S. – modeled International Classification of Diseases [ICD-10] to diagnose and treat mental health disorders. In other words, Ukraine is trying to move away from a state hospital based, socialized system of care to a privatized, market based, decentralized system of health care. These reforms, however are still in the theoretical or "testing" phase, with the exception of the ICD-10, which is in use to varying degrees.

Currently, while there is a push for community-based treatment, these types of centers do not exist. Instead mental health care is still found in the large state psychiatric hospitals, many built over a century ago. While some private, for-profit clinics do exist (not necessarily the same as community-based services) I was unable to observe or

interview anyone from such a clinic, or find anyone that had found treatment in such a clinic, which likely remains unaffordable to most. Individuals instead are serviced by a particular hospital according to where they live, zoned by address. The constitution of Ukraine, ratified in 1996, states that healthcare is provided by the government free of charge (Tarantino et. al. 2011:23); however in reality many patients have to pay for services and medications due to insufficient hospital budgets. And while mental illness the world over is usually associated with differing levels of stigma and discrimination (Cohen et al 2002), Ukraine has inherited a psychiatric system overshadowed by particularly disturbing legacies from the Soviet Union, where psychiatric diagnoses and confinement were used as forms of political repression (Korolenko and Kensin 2002; Lindy and Lifton 2001; Ougrin et al 2006; Van Voren 2002).

The transformations found in mental healthcare are part of a more general neoliberal trend taking place in Ukraine to dismantle and privatize historically centralized state institutions, such as fuel and energy, industry, transportation and construction (Elborgh-Woytek and Lewis 2002:8). For example, immediately after independence in 1991 until 1999, a total of over 50,000 companies were privatized (Toms et. al. 2002:27). Such reforms are being initiated from within and from outside of Ukraine; many changes initiated from outside are related to funding allocated by organizations such as the United States Agency for International Development (USAID), the World Health Organization (WHO), and U.S. federal funding that aims to "stregthen civil society." Monies from these organizations are being allocated to non-governmental organizations (NGOs) to promote change and reform from within. For example, Ukraine entered into an agreement

with the United Nations Development Programme (UNDP) for assistance in meeting the Millennium Development Goals and UNDP has supported national priorities relating to democratization in Ukraine in two major areas: institutional reforms to promote human rights and human rights based approaches, as well as civil society empowerment and participation in decision making (UNDP 2006:9).

Like many other newly independent nations around the world, Ukraine engaged in Structural Adjustment Programs (SAPs), also known as austerity measures, to receive funding from the International Monetary Fund (IMF) and World Bank. These programs reflected neoliberal policies and assumptions that promoted a particular set of requirements countries had to meet in order to sustain funding, such as reducing state funding for health care, education, and other social services. While the adoption of the ICD-10 is not directly stipulated as an area for reform, it does fall in line with neoliberal logic through the "westernization of the mind," or exportation of U.S. conceptualizations of mental illness and the human psyche (Watters 2010) and the opening up for global pharmaceutical marketing. The move for community-based mental health care and the adoption of insurance based care, however, are more directly related to neoliberal reform, where both will help cut social service expenditures through privatization and decentralization of the healthcare system. The core logic of neoliberal reforms demand that governments "cut social service expenditures, decrease industry protection, free interest rates, privatize state-owned enterprises, and set realistic currency exchange rates" (Shefner 2008:24) all of which are suppose to reduce state intervention while increasing competition and investment, in order to stimulate economic growth. Additionally,

neoliberalism explicitly promotes what is called "developed capitalism" along with its assumed sociopolitical concomitants such as individual civil and political rights and democratic institutions (Liu 2003:2). Policies reflecting the neoliberal agenda in Ukraine often promote "civil society and development" models (Phillips 2005a:502) and "strategies to instill initiative, independence, and Western-style individualism" (Phillips 2005b:254), in addition to privatization. In other words, neoliberal capitalist institutions and ideologies are being promoted in postsocialist Ukraine, including in the mental health care system.

Neoliberal reforms of the mental health care system in Ukraine are experienced as problematic, however, because they are forcing people to restructure their health seeking behaviors and to call into question their relationships to the state, community, and families as well as their morals, values, and identities. These reforms also include the Westernization of diagnostic criteria and diagnoses that encourage Ukrainians to frame mental health problems as biomedical in nature. Also known as medicalization, this process typically disregards environmental and societal forces acting on individuals and communities, shaping their experience with health and illness. However, medicalization is not an entirely new concept to Ukraine as it was also used under Soviet rule to hospitalize dissidents in psychiatric institutions, as well as to conceptualize disability (Phillips 2011) and childbirth and pregnancy (Rivkin-Fish 2005a). Today, however, medicalization in Ukraine is increasingly framed through "global mental health" approaches and the use of human rights discourse. Often these are used to combat the abuse of the mentally ill or disabled (Patel et. al. 2012), which is widespread in many

contexts, and certainly in Ukraine. The global mental health movement and the use of human rights discourse and the values associated with both "may have a liberating effect by creating new options for people limited by illness or untenable social situations, but it also creates ethical conundrums" (Kirmayer 2012:108). These ethical conundrums are rooted in the "global hegemony of psychiatric knowledge" (Kirmayer 2012:108), most of which originates from European and American notions of individualism and autonomy and are being exported around the world. In Ukraine, these ethical conundrums include dilemmas regarding the proper and humane diagnosis and treatment of the mentally ill as well as the problematic nature of reforms when structural and ideological frameworks to make such reforms possible are missing. It is important to note that human rights discourse has been appropriated by NGOs in Ukraine as a way to challenge "abuses of psychiatric power" (Kirmayer 2012:99). While there are documented cases of human rights abuses in Ukraine, such as wrongful confinement in psychiatric hospitals, other abuses, such as discrimination and mistreatment, especially by health care workers, or families and neighbors are being interpreted as human rights abuses. In this light human right language is used as a strategy for the weak and vulnerable to gain support to challenge the status quo, a ways to speak back to power in social and political struggles (Kirmayer 2012:101). There is another conundrum here however, because neoliberal reforms work to de-emphasize economic and social rights, and hence demote the idea of health as a human right.

Neoliberalism is widely associated with the World Bank and the International Monetary Fund (IMF) particularly because these institutions promote neoliberal policies

in countries that borrow money. The role that these institutions play in shaping a country in transition is considerable because of the differing ideals and structural shifts that they promote and enable through structural measures, such as individualism, private property, competition and free markets (McGregor 2001:84), which in turn exacerbate unequal access to resources. This is not to say that unequal access to resources did not exist under socialism; in fact an "economy of shortage" (Kornai 1980 from Verdery 1991:423) resulted in the back and forth bargaining and hoarding by enterprises. At first thought this seems impossible; since socialism was supposed to create a class-less society. However, the central legitimating principle of socialism was "rational redistribution," where the "bureaucratic apparatus justifies appropriating the social product and allocating it by priorities the party has set" (Verdery 1991:420). The bureaucracy needs the capacity to allocate resources, especially those that generate more resources, such as heavy industry, with a focus on allocation of resources, not increasing the amount to be allocated (Verdery 1991:421). In other words, under socialism the goal was to totally control the allocation of resources, not necessarily to provide quality products or increase availability of resources. The resulting shortages eventually lead to a "second" or "informal" economy, allowing individuals, families and small businesses to get the goods and income they needed by various means, such as hiding goods under the counter for friends, moonlighting for extra pay and so forth (Verdery 1991:423). Unequal access to resources continues to be a problem in postsocialist Ukraine, albeit the source has shifted from shortages due to bargaining and hoarding or "supplies" to one of "demand" or the maximizing of surplus value, or profit (Verdery 1991:423). Neoliberal economic theory

proposes that state bureaucracies should not be in control of the production and allocation of resources, but instead supply and demand should be decided by the "free market."

Biomedicine and Mental Health

From the vantage point of the mental health system, both the Soviet diagnostic and treatment methods of mental illness and those promoted under neoliberal reforms heavily rely on a biomedical model. As a result there are similarities, especially regarding psychobiological and pharmaceutical treatment methods, as well as differences. For example, the Soviet state emphasized collective economic rights, whereas neoliberalism (based on Western principles) emphasizes individual political rights and freedoms (Lambelet 1989:76). In the mental health setting the clashing of these ideals can be clearly seen in the Soviet view of "work therapy," where patients learned viable trades such as woodworking, sewing, and so forth, and sold their products with the monies returning to the hospital. Training patients in this fashion and allowing them to sell their products as a form of therapy is not supposed to be practiced any longer in Ukraine; the "reformed" mental health system claims this type of therapy infringes on the human rights of psychiatric patients. I address these dynamics in later chapters.

Another key difference is that the Soviet state was founded on the idea that the "collective is the unit of philosophical, political and legal primacy in the Soviet socialist system" (Lambelet 1989:72), whereas the neoliberal arrangement places emphasis on the individual and his or her efforts and successes. These reconceptualizations of the relationship of the individual to the state, community, and family have tremendous

implications. In the Soviet system, when an individual was seen as a threat to the collective (such as a dissident protesting against a perceived injustice), he or she was repressed, often diagnosed as "schizophrenic" (an issue I address later), and psychologically "re-educated" (Lambelet 1989:72-75). The underlying assumption of Marxist-Leninism (albeit hijacked by Stalinism and the basis for the Soviet socialist system) was that an objective, scientific force created and drove history, as opposed to a particular political philosophy (Lambelet 1989:73). Therefore to challenge the Soviet system was to challenge science itself; as a result the individual would be deemed mentally ill. One form of schizophrenia specific to the Soviet model characterizes this illness as "paranoid symptoms of over-evaluation of one's own importance, often exhibiting grandiose ideas of reforming the world" (Lambelet 1989:73). The Soviet system was therefore similar to current Western models of mental illness which tend to rely heavily on biological origins of illness, leaving little, if any space for moral and political critique, thereby allowing the use of psychiatry as a tool for social control (Kirmayer 2006:131).

Other important distinctions of the Soviet model of mental health care are located in the concept of "rights" – for example, a psychiatric patient in Soviet Ukraine was not deemed to have rights. In the Soviet model, rights were bestowed on people by the state, as opposed to the view that rights are "natural" or innate (Lamblet 1989:66). Another distinction is that the Soviet model was most concerned with economic and social rights (without which political and civil rights are seen as meaningless), whereas Western models have prioritized civil and political rights (Lamblet 1989:65). This helps explain

the rationalization behind the ”re-education of dissidents,” considered a humanistic gesture insofar as real democracy was also defined as government by the majority in the interests of all working people (Lamblet 1989:75). Dissent was thus seen as an “individual action against the people” (Lamblet 1989:72), and the only explanation had to be because of a mental illness. The Soviet emphasis on economic rights also meant that physical and mental health was necessary for full citizenship. An inability to work due to illness meant a loss of productivity – a basic attribute that a Soviet citizen was expected to possess (Luse and Kamerade 2012:5).

The transition away from this rigid incarnation of the Soviet model began to take shape before the 1991 independence of Ukraine, specifically with the restructuring policies of p*erestroika* and g*lasnos*t. Mikhail Gorbachev (leader of the Soviet Union from 1985-1991) legalized private, market-oriented enterprise for individual and cooperative businesses, allowed foreign investment in, and pushed for greater openness between political leaders and the populace (Remington 2008:44-45). These changes were made in order to preserve the Soviet system and modernize it through restructuring, which was in turn supposed to resolve what Gorbachev felt was a contradiction between the ideals of socialism and inconsistencies in its practice (Lamblet 1989:78; Subtelny 2009:574). It is argued that *perestroika* and *glasnost* inadvertently helped usher in a revival of national consciousness throughout the republics and eventually the dissolution of the Soviet Union (Dukes, Paul 1998:332; Remington 2008:47; Subtelny 2009:574).

It must be noted here that socialism like neoliberalism or capitalism is an “ideal-type model” and cannot really provide a faithful or genuine portrait of real conditions any

more than what is claimed under neoliberalism; there were more forces at work than these formal explanations. As such, the degree to which Soviet political, economic, and cultural ideals reflected - or masked - actual conditions of life is a matter of debate. For example, it has been argued that alongside these more formal explanations of life under Soviet rule there was a nonofficial sphere or "parallel culture," where "people recognized much ideological falsity and thus the principal reason for the perception of stability of the Soviet order was that certain conditions of everyday life were experienced by the majority of Soviet citizens as immutable" (Yurchak 1997:165). This allowed one to live a "normal" life and be "left alone" by the system through pretense or parallel cultural production, where instead of exhibiting "false consciousness," people became "cynical subjects" who were quite aware of what they were doing despite discrepancies with official explanations or ideology (Yurchak 1997:174). In other words, citizens might appear to believe in and follow the rules while not necessarily agreeing with them.

The major differences between the Soviet system and the one being adopted in Ukraine today, as well as the points of overlap identified above, have real implications for the transition of the mental health system in terms of service delivery, diagnosis and treatment. For example, to transition from a hospital based system (i.e. large state psychiatric hospitals) to community-based care (small hospitals or clinics in local communities) in simple terms has meant cutting the number of psychiatric hospital beds each ward offers and redirecting that money (where each bed = set amount of funding) from these hospitals to clinics within local villages or cities. However, because of the lack of basic infrastructure such as transportation, or even physical structures such as clinics

and hospitals within local villages or cities, this care is simply disappearing along with the funds (rumored to be pocketed by local officials). This has created a contradiction; on the one hand the reforms suggest that it is "inhumane" for patients to be crammed into large state psychiatric hospitals, while on the other "local" community based care options do not exist, patients cannot access or afford medications, and families are unable to care for them at home either physically or mentally.

Transitioning to private insurance-based care is still in the planning and testing phases, however the Ministry of Health has set the anticipated date to introduce the reform as early as 2015-2016 (Kiev Post 2011). Currently a pilot program of reforms is being conducted in four Ukrainian cities – Dnipropetrovsk, Donetsk, Vinnytska and Kyiv (Tarantino et. al. 2011:22). The overall goals of this program include reducing the number of empty beds in state psychiatric hospitals, strengthening the role of primary health care providers (PHC), allowing private sector health services to compete for funding from the public sector, and introducing mandatory social health insurance (Tarantino et. al. 2011:22). The expected outcome of these programs is to "change the budgetary model of the health system to a social insurance model" (Tarantino et. al. 2011:22).

Finally, the ICD, which has long defined mental health diagnosis and treatment in countries like the United States and was only officially adopted by the Soviet system in 1982 due to international pressure, especially from the World Psychiatric Association, is already in use (the current 10th edition) by many Ukrainian practitioners but with mixed reviews. There seems to be a divide between practitioners who were trained during the

Soviet era versus those trained after Ukraine's independence. While this reform is not directly linked to IMF and World Bank austerity measures, it does fall in line with market reforms since the Westernization of diagnoses and diagnostic categories, or the "globalization of the American Psyche" (Watters 2010) means the continued medicalization of mental illness in Ukraine and hence the opportunity for pharmaceutical companies to enter new markets.

In general, practitioners who participated in my research stated that Ukraine is "not ready" to transition to community based services. They are especially concerned about the abuse of mentally ill patients they have observed at the hands of family members, neighbors, police, and the state, as well as problems patients face in accessing quality medications and the lack of infrastructure that would make community-based care possible. However, these problems may be symptoms of a larger issue. Current anthropological research on the transition to neoliberal arrangements in the Arab world (but applicable to other countries) have noted that the remaking of cultural orientations are just as important as structural and policy changes (Pratt 2007:19). As a result these reforms are producing tensions between the philosophical and cultural underpinnings of socialism and neoliberal capitalism, such as how providers view their patients, where the responsibility for health lies, and the morality of money as a medium of exchange for services formerly provided by the state.

Entangled within neoliberal structural reforms are ideologies which shape not only economic activity, but also definitions of normal and abnormal behavior and what is moral and immoral. For example, emphasizing individual persons and individual efforts

and success is in direct contradiction with the Soviet emphasis on the collective and the social – focusing on one's self would be considered egocentric or selfish (Aronson and Field 1964:916) at best and politically subversive at worst. Soviet practitioners generally likened their patients to children and expected the patients to accept a state of dependence on the practitioner (or state) (Aronson and Field 1964:917). Within the neoliberal reformist view, however, the patient is not a dependent but an active participant in his/her recovery. This has posed issues for practitioners, families, law enforcement and policy makers who are now being urged to place responsibility for failings on the individual, ingnoring environmental, social and political economic factores which may be just as responsible. Essentially, Ukrainians are facing moral dilemmas daily regarding the proper and humane diagnosis and treatment of the mentally ill. Ironically, however these moral dilemmas are not really so different from those faced by practitioners under the Soviet system. For example, the hospitalization of dissidents also relied on "blaming the individual" which I discuss in greater detail in the following chapter. So, here we can see overlap or consistency between the logic of the Soviet and neoliberal (or postsocialist) systems where the individual is identified as the problem, not the system that shapes, defines, and interacts with the individual.

Aside from being characteristic of postsocialist transitions, I contend that these overlaps and consistencies are evidence that broadly speaking, political-economic systems shape and conceptualize health and illness (and the person) in particular ways. In other words who gets sick and why is directly related to political economy. This is because both systems entail particular kinds of structural arrangements in economy and

society (which may differ from each other) and particular ideologies that justify them and that make them seem "right and normal" to those who live in them. They are each hegemonic in their own way, however any hegemonic system is imperfect and rife with contradictions. Each one can be "seen through" by those who live within them, who may be critical but also powerless in practice to change the system or their own circumstances. For example, in the next chapter I will discuss how psychiatrists in the Soviet Union who challenged the practice of hospitalizing dissidents ended up hospitalized themselves. The common denominator here is that as total social systems the Soviet and neoliberal models do bear similarities to each other because any social system – even one that celebrates individuals - subordinates the latter to the larger systemic logic.

In either system dilemmas regarding the humane treatment of mental health patients force practitioners to either comply with the hegemonic logic or find ways to work around the system. In Romania a similar situation has led to practitioners creating new labels and venues for moral judgements. Jack Friedman (2009) writes that psychiatrists have created a new category of people called "social cases," deemed unable to survive outside of the institution because of poverty and a nonexistent welfare system. Instead of releasing these "social cases" back onto the streets, they are allowed to stay on at the hospitals as patients. Stillo (2011) writing about a Tuberculosis Sanatorium, also in Romania says that political and economic transitions, and austerity measures are forcing the medical sector to address social problems such as homelessness and unemployment, leading doctors to resist discharging patients who are without economic and social support. A similar situation exists in the U.S. where disability has been understood as

functioning to some degree as a way to redistrubute income where rises in unemployment have translated directly into increasing numbers of individuals filing disability claims (Kleinman 1988:9-10). Both systems have a tendency to medicalize problems as an alternative form of social control where medical institutions replace legal, religious and other mediators of behavior (Kleinman 1988:9).

Neoliberalism is the latest interventionist philosophy shaping the world which gives justification for change and reform. I argue that the reform of the mental health system in Ukraine is more than just structural and economic reform; it is also about physical, cultural, and ideological restructuring. Patients and providers alike are required to reorder their entire meaningful worlds (Verdery 1996:35). They are being "forced to bear the 'external shocks' of a global system in crisis" (Nash 2005:2), and are "expressing the pain of a system out of joint" (Kirmayer 2006:138). However, I argue that the reforms proposed in Ukraine highlight the tensions inherent in both the Soviet and neoliberal systems and contain elements that overlap. Under both systems, biomedicine and discourses of science and particular ideological constructions of the individual and his /her relationship to the state, society have been utilized to legitimate the political-economic arrangement. Additionally, my findings suggest that neoliberal reforms of the mental health system are still largely at the stage of discourse and discussion and so the changes they may promote have not yet fully occurred. Therefore paying attention to the nuances and overlapping dynamics among the two systems highlights how political economies and power structures shape health and illness. In this respect neoliberal-style reforms are not so very different from the Soviet system they are

supposedly replacing. My research explores these tensions, overlaps, and reorderings through psychiatric patients and providers in order to see through the eyes of those experiencing these economic and political reforms.

Methods

My interest in mental health originated early on in my academic career. I had much experience with mental health issues in the U.S. through my Master's thesis at the University of South Florida where I interned with the National Mental Health Association. I had also worked at a community mental health center, and grew up with a parent with mental illness. I felt Ukraine would be an interesting place to study mental health for a number of reasons: the number of anthropologists working in this part of the world remains relatively small. Moreover, because of its history Ukraine seemed a good place to study the relationship between mental health, psychiatry and politics. And, possibly the most convenient reason I chose Ukraine is that my husband was born there.

More directly, however my interest in the field of mental health was fueled by my sincere desire to understand my mother's struggle with mental illness and her constant battle to stay afloat. Her relationship with the mental health system in the U.S. only made things worse; she has been given several different diagnoses, each with its own set of prescriptions. She struggles on a daily basis with the side effects of medications, and it's a full time job keeping up with the paperwork to qualify for Medicaid and various other programs for housing, treatment and medications. This "system" that my mother has had to navigate on a regular basis was the result of changes that came about during

the 1960's and 1970's, known the world over as "deinstitutionalization." Therefore while conducting my research in Ukraine I began to learn that the country was in the midst of reforming the mental health system and that it was to be shaped in the image of the same system that my mother suffered through. It was these kinds of factors that shaped my assumptions and findings within this dissertation.

My research in Ukraine was conducted from June 2008 until January 2010 primarily in an urban city in the south-central part of the country where I gathered most of my data on the campus of a state-run psychiatric hospital. This was supplemented with additional research periods in the capital city of Kyiv at a rehabilitation clinic that focuses on art therapy and was also located on the grounds of a state-run psychiatric hospital. I chose the research site in south-central Ukraine because this is where my husband grew up. This enabled me to utilize family contacts, as well as access to housing, childcare and so forth. Access to the psychiatric hospital was enabled through my contact with the president of a non-governmental organization (NGO) called Human Rights for Psychiatric Patients (HRPP), a pseudonym. It was through my affiliation with this organization that I also gained access to the rehabilitation center in Kyiv. Both of these state-run psychiatric hospitals looked similar to university campuses, and both were comprised of several separate buildings laid out over very large tracts of land, which at one time were completely surrounded by forests, separate from the urban cities they serviced.

Figure 1 Administrative Building of state-run Psychiatric Hospital in South Central Ukraine

Both campuses were quite beautiful, especially in the summer; all over visitors could find outside benches, flowers and many trees and paths for walking. While the outside façade of each of the buildings that comprised the hospital were quite old, recent renovations had taken place inside many wards, much of them funded by the hospital staff themselves. Each "ward" was a separate three or four story building. There were also separate buildings where food was prepared, an administration building where offices for staff were housed, as well as a separate one story building that housed the

rehabilitation clinic and the offices of HRRP, a patient-run organization whose goal is to educate clients, families and the community regarding their rights to psychiatric treatment and to end the human rights abuses to users of psychiatric services.

Most of my observations and interviews took place at the state-run psychiatric hospital in South-Central Ukraine and it is important to note that it is probably not exemplary of other psychiatric hospitals in Ukraine for several reasons. For example, one year the hospital won the distinction of being the "best hospital in all of Eastern Europe" (personal communication with head of psychiatry hospital 2008). No other hospital had an NGO presence directly linked to it whose express mission was to defend the rights of patients; HRRP and the rehabilitation clinic it ran was also located on the campus of this state-run psychiatric hospital in south-central Ukraine. Therefore I do not feel that my observations are representative of psychiatric hospitals more generally. From my understanding the conditions found in other psychiatric hospitals around Ukraine range from tolerable to deplorable.

Figure 2 Rehabilitation Clinic on the campus of the state-run Psychiatric Hospital in South Central Ukraine where HRPP's headquarters were housed.

The data gathered for this research relied on several qualitative methods, including participant observation, observation of patients and practitioners, as well as observations of the activities of the non-governmental organization HRRP. Other methods included interviews and focus groups, as well as literature reviews, archival research, and the collection of public documents such as mental health literature available to educate patients and their families and newspaper articles. Throughout my fieldwork I

kept a detailed electronic journal of my observations and activities in addition to a personal diary/journal. Interviews were transcribed into English and after returning to the U.S. I began to analyze the data. During the analysis phase I continued to gather data when needed through literature reviews, scanning of media such as newspapers, journal articles and Ukrainian news organizations, in addition to email communication with my sponsor in Ukraine.

Before my research began I contacted HRPP through email and telephone and they agreed to sponsor my research. HRPP focuses its efforts on helping psychiatric patients as well as the families of these patients navigate the psychiatric environment as well as mitigate abuses that patients often suffer. These abuses range from forced hospitalizations, taking over of a patient's apartment by family and nonfamily members and unequal access to legal services, to name a few. In addition to a rehabilitation clinic, HRPP manages educational programs for those with a diagnosed mental illness and their families, and advocates for patients if they go though the legal system, such as an arrest following neighbor's complaints, or when challenging family and relatives for property, parental, or guardianship rights. The organization at the time of my research had 150 active members in fourteen regions of Ukraine but was based in the state-run psychiatric hospital located in the South Central part of the country. While HRPP has one psychiatrist acting as deputy, it is a patient-run organization, meaning that all members have been registered at some point at a psychiatric hospital as a patient or have family members that have been registered. I worked most closely with the president of HRPP (not the same person as the deputy) who provided much support and direction for my

research. During my time in Ukraine I was able to observe the daily workings of the organization, from consultations with patients and families who have lost housing due to their hospitalizations, to educational seminars aimed at helping social workers and mental health advocates better understand the current laws and rights of patients. HRRP has been funded by organizations such as USAID, and others that promote civil society, such as the Soros Foundation through the International Renaissance Foundation. HRRP could be understood as an organization that is "filling in the cracks" where services provided by the state are shrinking or failing.

My connection with HRRP enabled further observations and research opportunities in Kyiv. My sponsor, a former psychiatric patient turned advocate and now president of HRRP, often made trips to Kyiv for press conferences where he would speak with news agencies about the conditions found in state-run psychiatric hospitals. It was here that I was introduced to many individuals with vested interests in mental healthcare reform, such as members of the Ukrainian Psychiatric Association. It was also in Kyiv that we visited another rehabilitation clinic located on the grounds of a state-run psychiatric hospital (the second hospital I mentioned previously). This rehabilitation clinic was unique in that it focused its efforts on rehabilitation through art. I was able to visit this clinic twice and conducted four interviews with social workers and staff who taught painting and ceramics to patients. It must be noted here though, that many mental health providers are also patients, or have been patients at one time, so the lines between patient and provider are often blurred. I also visited Kyiv for other activities; for example in May 2009 my sponsor was invited to participate in a bioethics conference at a

university and invited me to attend as well. This gave me insight into the kinds of research and topics by Ukrainian professionals focused on outside the psychiatric hospital.

Figure 3 Artwork near Children's Ward on campus of state-run Psychiatric Hospital in Kyiv

In addition to observation and interviews in psychiatric settings I also conducted five individual oral history interviews with three men and two women who were old enough to remember the famine of 1934. Initially, I had wanted to research psycho-

social trauma to understand how citizens individually and collectively conceptualize, articulate, and treat the negative effects arising from chronic and recurring trauma such as from war, famine, political repression and radiation exposure. This goal began to take less precedence as my research began to focus more and more on the transitions of the mental health system. The shift in focus was mainly due in part to my close association with the president of HRPP as he was trying to manage and understand these transitions and the accompanying discourse. These early interviews with elderly individuals were still of value especially with respect to understanding life under the Soviet system, however. For example, all five of my interviewees were quite nostalgic of the Soviet system despite the numerous tragic events they experienced and were greatly concerned with the new direction their country was taking economically and politically.

In total, I conducted forty semi-structured interviews (open-ended questions following a general list of topics) with psychiatrists (6), social workers, mental health advocates (15) and patients (19), although not all individuals fit only in one category as some social workers have been patients. To recruit participants, I spent several hours, two to three days a week in the rehabilitation clinic at the psycho-neurological hospital in South Central Ukraine where I casually asked patients that showed up voluntarily if I could interview them. When my sponsor had time he would take me to meet providers such as psychiatrists and social workers, from whom to solicit interviews. His assistance was necessary, as I could not just walk into a ward by myself where most providers would be found behind locked doors. I would liked to have conducted more interviews, however five months before my fieldwork ended the Swine Flu appeared in Ukraine and

the patients at the psychiatric hospital were quarantined – this abruptly put a stop to my ability to locate patients and/or providers to interview. Additionally, my ability to travel to other hospitals or participate in other venues was limited due to lack of funding, since for the most part I funded my own research. These qualitative methods such as participant observation and interviewing, as opposed to more quantitative methods, allowed me to gain the trust necessary to facilitate personal disclosure of information regarding traumatic experiences, mental health impairment and treatment.

While still in residence at the University of Tennessee I took two years of Russian language instruction which supplemented my own previous Russian language knowledge. During fieldwork, however I did utilize an interpreter (my husband) for all interviews gathered to ensure greater comprehension. The use of an interpreter was also beneficial because I was not able to learn the Ukrainian language which is also spoken with varying degrees in different regions but especially among younger generations. Generally, I would begin each interview by introducing myself and what my research was about, often facilitated by an introduction by my sponsor who set up the interviews. After obtaining written informed consent, I would then begin asking questions from a standard list that I had prepared in advance. I did not always follow these questions exactly; they were used mostly as a flexible guideline that allowed me to focus on and further probe topics that were important to the respondent. Additionally, I did begin to alter some of my questions when I realized my focus needed to include the transitions taking place in the mental health system. I was able to record most of my interviews, although a handful of patients and one doctor did not want to be recorded; no other testing materials were required.

Most of my interviews lasted approximately one hour, although some of the patient interviews were much shorter. For example, one patient was quite withdrawn and would not answer many questions, while another found himself unable to speak. In two instances focus groups spontaneously occurred with several providers (advocates and social workers), which proved quite interesting because these groups highlighted the contested nature of the different reforms being promoted in Ukraine. According to the terms of informed consent procedures, I have protected the privacy of my informants by using pseudonyms. Included in the appendix is a list of my interview questions.

Soviet/Ukrainian History

A brief discussion of Ukraine's long and complex history is necessary to situate the more immediate history of post-independence, post-Soviet reforms as they interface with longer-term historical and socio-political patterns. Later in the dissertation, I will return to this history and compare it with the subjective experiences of my informants to explore how life was experienced under Soviet rule and how this relates to the cultural and socio-political patterns significant today with respect to mental health and mental healthcare issues.

Early Soviet Rule

It is important to consider Ukraine's traumatic history and legacy of suffering when addressing current issues with mental health and mental healthcare. As it turns out, a grand project to transform Ukraine economically, politically and culturally has

happened before the current period of transition. In 1921 Ukraine became the Soviet Socialist Republic of Ukraine – it remained under Soviet rule for 70 years, until independence in 1991. The beginning of Soviet control of Ukraine in the 1920s is "viewed by many as the golden age for Ukrainians" (Subtelny 2009:380). In 1921 Lenin introduced his New Economic Policy (NEP) whose goal was to transform Russian society into an "ideal, classless, communist state" (Magocsi 2010:585) and "recuperate from the Civil War" that pitted Bolshevik and anti-Bolshevik against each other, also known as the Red and White Armies (Subtelny 2009:381). Under the NEP, collective farms were abandoned, grain was no longer requisitioned, and the Soviet government imposed a moderate tax. After paying the tax, peasants could sell surplus grain at any price (Subtenly 2009:381). In other words, Lenin compromised with capitalism temporarily in order to create a socialist economy. As Katherine Verdery (1991:419) wrote, "socialism was the longest and most painful road from capitalism to capitalism."

In 1928 the concept of a planned command economy where all decisions were to be made at the center in Moscow and implemented through the Soviet Union was implemented by Stalin (Magocsi 2010:589). As a result the first Five-Year Plan (FYP) was adopted, which aimed to transform "the entire labor force in the countryside as well as the city into employees of state-controlled enterprises" (Subtelny 2009:405) through rapid industrialization and collectivization (Magocsi 2010:589). Collectivization meant that farmers had to give up their lands to work together on communal farms. Ukraine would be responsible for growing food to supply to the rest of the Soviet Union. Most of Ukraine's farms and livestock were forcibly collectivized by March 1930 (Magocsi

2010:592). Ukrainian peasants did not give up their lands without a fight; rather, they slaughtered their livestock, burned their fields, protested with armed insurrections, or moved to cities as forms of resistance against the Five Year Plan (Magocsi 2010: 593; Subtelny 2009:411). The wealthier peasants who resisted collectivization, called *kulaks*, were labeled "enemies of the people, and presented as wealthy land-grabbing exploiters of their fellow villagers" (Magocsi 2010:594). Those labeled as kulaks were eventually rounded up and shipped to Central Asia, Siberia, and the Soviet Far East, and by 1930, nearly 62,000 kulak households had been eliminated (Magocsi 2010:594). The "dekulakization" of Ukraine was carried out by a group called the "twenty-five thousanders," who were mostly workers from Russia as well as 7,000 urban Ukrainians who supported the building of socialism (Magocsi 2010: 595; Subtelny 2009:410). Backed by soldiers and the secret police, they "expropriated kulak property, organized collectives and supervised grain shipments" (Magocsi 2010:595).

In 1932, a law was put into place where anyone caught "taking anything from the collectives - even an ear of wheat or the broken root of a sugar beet – could and often did result in confiscation of property, a ten-year prison term, and even execution" (Magocsi 2010:600) while at the same time famine had already started spreading (Subtelny 2009:414). The exact causes of the famine of 1933 are often contested, however, there is agreement that "several million deaths did occur in Soviet Ukraine during the Great Famine of 1933" (Magocsi 2010:600). The famine or *Holodomor*, of the 1930s is heavily contested today by Ukrainians and Russians alike. The official Ukrainian view was that it was a deliberate act of genocide against the Ukrainian people (Chopivsky

2011), instigated by Stalin. Mace (2009:79) describes the famine as resulting not just from the struggle between Russian and Ukrainian nationalists, but also a "social struggle of the countryside verses the town where even the working class was drawn from the oppressor nation or had assimilated its culture." In other words the famine was preceded by class struggle between the peasants of the countryside and the working class of the urban towns, as well as the push from Stalin to root out Ukrainian nationalism (Mace 2009:83). The Russian view is that it was not ethnic genocide against Ukrainians but an act of violence against all peoples in the Soviet Union resulting from disastrous agricultural policies (Chopivsky 2011).

Ukrainian experiences of trauma intensified during World War II; five million Ukrainians were killed, over five million were deported to concentration camps, and more than ten million were left homeless (Wanner 1998). The war lasted the longest in Ukraine and caused the most devastation there because the German and Soviet armies passed through the country twice in advance and in retreat (NPR 2010). Germany launched a surprise attack against the USSR on June 22, 1941 and by December the Germans occupied almost all of Ukraine (Subtelny 2009:460). German troops continued to occupy Ukraine until 1944 when the Soviets returned. When Erich Koch was appointed by Hitler as the Nazi ruler of Ukraine he gave this speech to his staff:

> Our task is to suck from Ukraine all the goods we can get hold of, without consideration of the feelings or the property of the Ukrainians. Gentlemen, I am expecting from you the utmost severity towards the native population (Koch in Subtelny 2009:467).

Rather ironically, however, it was during the German occupation that Germany ran a campaign in Ukraine to convince Ukrainians to rebel against Soviet rule. One project undertaken in 1943 - in the same town I conducted my research - unearthed 91 mass graves with over 10,000 mostly Ukrainian men and some women, all executed by Soviets with two shots to the back of the head with their hands tied behind their backs (Dragan 1986).

After WWII Ukraine's borders widened and now included Galicia (Western Ukraine) (Magocsi 2010:685), however there was much physical destruction left behind. In 1946 the fourth Five-Year Plan was implemented; "Soviet Ukraine's industrial base was reconstructed, and by 1950 its gross output had already exceeded that of 1940, the last full year of peace before World War II struck the country" (Magocsi 2010:692). Postwar construction also included 3,400 new schools in Soviet Ukraine (Magscsi 2010:695), as well as the rebuilding of buildings and infrastructure damaged during WWII.

With Stalin's death in 1953 there were several years of what is termed the "Khrushchev thaw" or "de-Stalinization," when Nikita S. Khrushchev became the leader of the Soviet Union (Magocsi 2010:701). It was during this time that Crimea was given as a "gift" to Ukraine, traditionally the "homeland of the Crimean Tatars whom Stalin had expelled during the Second World War" (Subtelny 2009:499). The "thaw" was characterized by at least four other developments: amnesty for prisoners accused of "anti-state" crimes, the rehabilitation of nearly one-third of 961,000 residents of Ukraine arrested on political charges during the Stalinist era, the establishment in 1958 of the first

permanent Soviet Ukrainian mission to the United Nations, and an increase of ethnic Ukrainians in the ranks of the Communist party of Ukraine (CPU) (Magocsi 2010:703). For the next decade it could be argued that the "de-Stalinization" or "thaw" did succeed in transforming Soviet society from one plagued by terror and Stalin's draconian measures to a more managerial system with an advanced industrial society (Subtelny 2009:509). The Soviet Union after Khrushchev was led by several short term leaders, such as Brezhnev, Andropov, and Chernenko.

Late Soviet Rule

In March of 1985, Mikhail Gorbachev was elected to become the new general secretary of the Soviet Union. He initiated the policy projects of *perestroika* (restructuring) and *glasnost* (openness) aimed to reform and democratize the Soviet Union while promoting more freedom of information and speech. This was done through political and economic restructuring, including the decentralization of industry and agriculture and allowances for some private ownership. This more "democratic" style of leadership also called for more openness in the conduct of government (Subtelny 2009:534). However, tragedy struck Ukraine on April 26, 1986 when the Chernobyl nuclear reactor exploded after engineers tested how long the generators of Unit Four could operate without steam supply if there were a power failure (Petryna 2002:1). The disaster began when a power surge followed the test, and the unit exploded at 1:23 a.m. It was eighteen days before Mikhail Gorbachev acknowledged on television that the disaster had happened, and as a result tens of thousands of people were exposed to

radioactive iodine – 131 (Petryna 2002) which is absorbed very quickly in the thyroid. 150,000 people were evacuated from the contaminated area and by the year 2000, four thousand cases of thyroid cancer had been diagnosed in exposed children. This failure on the part of the Soviet Union to inform the citizens of Ukraine of the accident coupled with the unintended effects of *perestroika* and *glasnost,* such as renewed nationalism, the return of exiles, renewed contacts with the diasporas and the rebirth of the Ukrainian (Greek) Catholic and Autocephalous Orthodox churches, all led to the eventual independence of Ukraine (Subtelny 2009:574; Magocsi 2010:719-724).

After Independence

Throughout Ukraine's history there were many uprisings against its occupiers, however with the dissolution of the Soviet Union in 1991 Ukraine finally declared its independence (although there was another very short period when Ukraine declared itself independent in 1917, which only lasted a week). One Soviet republic after the other began to declare independence from the Soviet Union and on December 9, 1991 a declaration was issued that dissolved and replaced the Soviet Union with the Commonwealth of Independent States (CIS) (Remington 2008:49). Ukrainians remember this time as full of economic and political hardship. Additionally, the authoritarian leanings of Leonid Kuchma (the first elected president of Ukraine) in addition to corruption from oligarchs led to an increase in corruption that filtered down to all levels of society (Magocsi 2007:307).

Ukraine's independence in 1991 was associated with a severe economic crisis. In the early days of independence there was hyperinflation with the ruble (form of currency) and "miserable economic failure" (Åslund 2009:246). This sustained economic crisis, which lasted almost a decade, also negatively impacted people's physical and mental health and life expectancy (Lekhan et. al. 2004:6). Hyperinflation "wiped out the savings of millions of frugal, hard-working citizens," especially the elderly, leaving millions of Ukrainians penniless (Subtelny 2009:620-621). Orest Subtelny (2009:618) writes that

> Between 1991 and 2000, the country's GDP had sunk over 63%, one of the worst declines in the former USSR. Its trade plummeted, debts burgeoned, and foreign investment was little more than a trickle. Villages were neglected and the urban infrastructure was in disrepair. People were badly fed, shabbily dressed, inadequately housed, and in poor health. The standard of living plummeted to the point where about 70% of the population were close to or below the poverty line.

One of the economic costs of independence from the Soviet Union was that Russia was the main market for Ukrainian products, and Ukraine's industry was heavily concentrated in the military-industrial sector – products that were no longer useful to national residents (Subtelny 2009:619). Additionally, while the majority of the citizens of Ukraine were plummeted into poverty, many elites were able to take advantage of the chaos and transformed party funds and property into private holdings, becoming wealthy oligarchs (Subtelny 2009).

In 1992, Ukraine changed its currency from the ruble to a provisional currency, called *Karbovanets* or coupons (Subtelny 2009:620). During these early years the "goal was to keep up production at all cost, even if no one wanted the goods that were produced, and to avoid unemployment" (Subtelny 2009:620), which eventually led to

extreme inflation. This was followed by the introduction of the *hryvnia* (Ukrainian currency) in September 1996, resulting in deregulated prices and trading (Åslund 2009:246-250) in addition to the privatization of business and property. Referred to as "shock therapy," these measures were intended to help Ukraine achieve economic stabilization but instead produced economic stagnation. During the early years of Ukraine's independence the International Monitory Fund (IMF) intervened to restructure the economy. It was in 1994 that Ukraine began to listen to the suggestions of the IMF and for the next decade the latter was highly active in Ukraine. Ukraine however preferred "gradual" reforms towards a market economy (Aslund 2009:44), unlike other post-Soviet countries like Russia or Poland who opted for more intense versions of shock therapy. The IMF gave Ukraine credits totaling 2.5 billion USD (about 3.5 billion) in stabilization funding from 1994 to 1999.(Åslund 2009:250).

In the 1990's Ukrainians were falling deeper into poverty, but in the 2000s the economy seemed to be improving. The signs of improvement could be seen in steel, coal, and the growth of small businesses and in the countryside private ownership of land completely replaced state ownership (Subtelny 2009:661). Just as other nations around the world, however, Ukraine entered into a new financial crisis in 2008 and again sought help from the IMF resulting in a "Stand-By Arrangement" in the amount of 16.4 billion USD (Åslund 2009:251). Despite the crisis however, "foreign investment in the country grew by 54% more than in the previous year …. [which] went into banking, agricultural enterprises, car dealerships, retail malls and outlets, hotels and machinery manufacturing" (Subtelny 2009:662).

Figure 4 Entrance to brand new mall build in 2009, one of three new malls built in the same year in the same town.

This overall historical narrative does suggest that the postsocialist transition has been very gradual and seems to have been initiated before Ukrainian independence. It has even been argued that this gradual change has been a pretext for "doing nothing" (Åslund 2009:44). Focusing on this postsocialist period is important for us to understand current reforms of the mental health system, especially since most of the reforms exist only in discourse. As Phillips (2005:441) writes, "socialism 'still matters' for the ways in

which people think of their societies, experience institutions of the state and the market, shop, seek out support networks, engage in entrepreneurial practices … in short, for how they live their lives."

Conclusion

This history of Ukraine more generally helps to set up the goal of this dissertation, which is to explore the reordering or transformation of the mental health system in Ukraine through the eyes of those experiencing economic and political reforms - patients and providers - as well as the similarities and differences between the different political-economic contexts. In the next chapter I begin by taking another step back to look specifically at the history of psychiatry and mental health care during the Soviet Union, the system Ukraine inherited with its independence. This history is important because the reforms promoted in Ukraine today are partly a reaction to Soviet injustices performed through psychiatry. For example the push for community mental health services could be understood as a welcome change from large state-run psychiatric hospitals, many of which are a century or more old and the site where dissidents were hospitalized. Reviewing this history will also contextualize the current reforms and their limitations.

Following this history I will discuss neoliberal economic policy which promises to combat poverty through economic growth by focusing primarily on privatization, deregulation and decentralization. I argue that neoliberalism is more than economic theory; it is instead imbued with social values and meanings that require the remaking of cultural orientations and have attached specific organizational forms, socio-cultural

norms and political ideologies such as democratization and civil society. Following from this discussion I then address two issues associated with democratization. The first deals with the question of whether Ukraine is transitioning away from an authoritarian state towards democracy or whether it is masking authoritarianism within democratic language and institutions. I argue that it is too soon to make this call; instead I believe that Ukraine is in a "grey zone" occupying a diversity of positions between authoritarianism and democracy (Pratt 2007:194). The second issue deals with the contradiction between neoliberalism or capitalism and democracy where capitalism has become a threat to democracy. The last section of this chapter I outline my theoretical orientation which heavily relies on critical medical anthropology (CMA), also known as the political economy of health, but also includes Ecological and Interpretive approaches.

The third and forth chapters draw on my original interview data and fieldwork observations. The third chapter focuses specifically on the structural discrepancies associated with mental health reforms in Ukraine. I show that these reforms are producing tensions between the philosophical and cultural underpinnings of socialism and capitalism, such as how providers view their patients and where the responsibility of health lies. I also consider structural issues that exist with regards to the transition from the hospital to the community, such as the lack of community infrastructure and funding and how the morality of money plays into these. These structural problems and tensions are also grounded in the cultural and philosophical differences between socialism and capitalism. However, there are also similarities, such as the process of medicalizing suffering and the conceptualization of individuals. While the Soviet system downplayed

the individual ideologically and the neoliberal discourse elevates the individual ideologically, they both end up sacrificing individuals for the collective interest of the most powerful classes.

In the fourth chapter I consider mental health care, diagnosis and treatment issues associated with the adoption of the ICD-10 diagnostic and statistical manual such as the applicability of applying the Western biomedical model cross-culturally. However, the biomedical model needs to be broadened to include the Soviet version of biomedicine. I argue that mental illness is not always completely biological, but also culturally shaped, and therefore a "one-size-fits-all" approach to diagnosis and diagnoses becomes problematic. For example, specific behavioral adaptations were learned while living under an authoritarian regime that are no longer useful and instead contribute to difficulty in adapting to the changes after the break-up of the Soviet Union, traits when understood through the biomedical model become symptoms of mental illness. I end the chapter with a discussion of how social problems more generally are being redefined as medical in nature, where issues such as gender relations, alcoholism, poverty and environmental disasters are now also subject to medicalization. This redefinition places the responsibility for larger societal issues on the individual and ignores social and environmental underpinnings of suffering, a dynamic that was also operative in the Soviet system. I argue that because of this similarity, Ukraine is actually receptive and susceptible to these medicalized discourses in the postsocialist moment.

CHAPTER I

Political-Economic Determinants of Health

As stated in the previous chapter, neoliberal reforms of the mental health care system in Ukraine are experienced as problematic. These reforms are forcing people to restructure their health seeking behaviors, to call into question their relationship to the state, community, and families, as well as their morals, values and identities. However, these might not be so problematic if infrastructural conditions existed that would enable improvement and accessibility of care. Also, the historic role of the psychiatric hospital as an extension of the state and as a way to control and shape political behavior is especially important. Until Ukrainian independence, any challenge to the Soviet system was a challenge to "science" itself (as defined by the state) and diagnosed by psychiatrists as a form of "schizophrenia" (van Voren 2009:1). Once deemed mentally ill, a patient lost all access to economic, political and civil "rights," and only through the individual's re-education could s/he gain back those rights. Additionally, patients became dependent on the psychiatrist and state-run hospital. These kinds of conceptualizations and relationships greatly contrast with the current system, where neoliberal reforms assume that civil and political rights are innate and inalienable and place responsibility for health on the individual patient. Transitioning from the Soviet system has meant that psychiatrists and patients alike have to unlearn old patterns, such as the paternalistic relationship of the psychiatrist to the patient and the state provision of services. I will now look more closely at the discipline of psychiatry during the Soviet period.

The Politicization of Psychiatry

Before the Bolshevik Revolution of 1917, psychiatry in Russia was focused on individual psychotherapy and psychoanalytical counseling. Freudian approaches were well respected (Yakushko 2005:161), and many psychiatrists were trained in other parts of Europe, particularly Germany (Korolenko and Kensin 2002:51). However, things changed drastically in the 1930s under Josef Stalin's influence. Stalin felt that psychoanalysis was hostile to the system and, as a result, anyone practicing it was considered too idealistic, prompting an official ban (Korolenko and Kensin 2002:54). Stalin associated mental disorders with the capitalist-oriented West, where certain social conditions (allegedly absent in socialist society) allowed for "abnormal, unfavorable, and destructive conditions" (Korolenko and Kensin 2002:55). Additionally, anyone caught practicing psychoanalysis was considered reactionary (Yakushko 2005:162), since psychoanalysis focuses on needs of the individual instead of the needs of the collective.

Because Stalin sought to establish that his regime was superior to all others and best served the needs of the populace, he promoted the idea that mental illness and drug addiction – regarded as arising from the stresses of capitalism – were not possible under Soviet rule. Drawing on state-controlled medical studies, he sought the support of pseudo-statistics to prove his point, while his policy further encouraged falsification of data by researchers who feared becoming labeled political dissidents themselves (Korolenko and Kensin 2002). Psychiatry, however, was still practiced in the Soviet Union, but became both medicalized and politicized as it was broadened to include political dissidents who resisted state authority. In other words, individuals who did not

subordinate their needs to the collective (represented by the state) were considered a threat to society at large. People deemed mentally or socially unfit were placed in prison-like mental institutions (Yakushko 2005:162), where they received medications, as opposed to counseling or psychoanalysis (talk therapy) to help with their illness, which in the case of political dissidents would usually be diagnosed a form of schizophrenia. According to the psychiatrists I spoke with, psychoanalysis or talk therapy is now once again practiced in Ukraine, however, I was unable to interview anyone in this field.

European, American and Russian concepts of schizophrenia developed in a similar fashion in the 19th and first half of the 20th century (Lavretsky 1998:549). At the time Europe tended to follow Emil Kraepelin's theoretical models which tended to be very biologic or medicalized, the U.S. tended to follow Eugen Bleuler's theoretical models which tended to be more psychological, while Russia embraced both until the 1940's. Currently American psychiatry embraces a *neo-Kraepelinian,* or "return to the medical model" (Compton and Guze 1995:201) approach to diagnosis and classification of schizophrenia, which has actually brought the American and European models closer (Lavretsky 1998:549). With the embrace of the medical model in European and American concepts of schizophrenia and mental illness more generally, I believe these models are more in line with Soviet concepts of schizophrenia and mental illness.

For example, the Soviet mental health diagnostic system placed a heavy emphasis on schizophrenia and was developed in the 1960s by Andrei Snezhnevsky, who was the founder of the very prestigious Moscow School of Psychiatry that held a monopoly over research and training of psychiatrists for almost 40 years, from 1950's to his death in

1987 (Polubinskaya 2000; Reich 1991; van Voren 2009, 2012). As Reich (1991:105) writes "by the middle and late 1970s the hegemony of the Moscow School in the realm of psychiatric theory and practice, particularly diagnostic theory and practice, was almost complete: it was clearly the dominant force in Soviet psychiatry, and its diagnostic system was the standard Soviet approach to the diagnosis of mental illness".

The most common diagnosis associated with Snezhnevsky during Leonid Brezhnev's time (1964-1982) was "paranoia" or "sluggish schizophrenia" (Ougrin et al 2006:458, van Voren 2009), with symptoms that included "struggling for the truth," "perseverance," "reformist ideas," and "a willingness to go against the grain" (van Voren 2002:132). Here "psychiatry was used as a tool for the elimination of political opponents or 'dissidents' and therefore "every kind of behavior that did not coincide with socially approved patterns could be attributed a psychopathological meaning" (Korolenko and Kensin 2002:59). To explain how the psychiatric community supported this logic, Robert van Voren (2002) writes that Soviet psychiatrists were alienated from the world outside the Soviet Union, and were trained to think that private initiative, independent thinking, and going against the grain were negative traits. Despite this prevalent logic, some psychiatrists spoke out against these practices and were sometimes hospitalized themselves as dissidents (van Voren 2010).

Psychiatry was predominately defined as a biomedical discipline, where psychiatrists tried to emulate somatic medicine or the perspective that disease results from genetic, infectious or toxic agents, or from traumatic brain injuries (Korolenko and Kensin 2002:57). Significantly, this meant that the role of social and psychological

factors in diagnosing and treatment were absent. Training of psychiatrists focused on teaching how to "single out signs of psychopathology" (Korolenko and Kensin 2002:56). As a result, "diverse psychological phenomena were interpreted as psychopathological signs and utilized in the construction of diagnosis of a mental illness." (Korolenko and Kensin 2002:56). For example, if a patient said he disliked a relative, the psychiatrist considered this proof of an inappropriate emotional reaction, the core syndrome of schizophrenia (Korolenko and Kensin 2002:56). According to this logic, psychiatrists were compelled to understand that resistance to the Soviet state – in which the state was viewed as a benevolent father – was a sign of mental illness. Therefore psychiatrists used psychobiological treatments for political dissidence and routinely abused citizens regarded as dissidents through physical, pharmacological, and psychological means. The only "cure" for such a patient was for him or her to publicly denounce their anti-Soviet views (Ougrin et al 2006:457). As a result, doctor-patient relationships were often adversarial ones, and psychiatrists believed that patients tried to hide their symptoms or signs of illness. Thus it was up to the psychiatrist to unravel these hidden signs through tactics reminiscent of police investigations (Korolenko and Kensin 2002:56).

In the 1960's, the psychiatric establishment in the U.S. and Western Europe began to learn of the abuses inherent in psychiatry in the Soviet Union. As a result, the World Psychiatric Association (WPA), an international organization that set forth an ethical code of conduct for psychiatrists worldwide, repeatedly denounced the political abuse of psychiatry, and instead of risking expulsion, the Soviet Union suspended its membership in the WPA (Ougrin et al 2006: 457). In 1982, possibly in reaction to international

pressure and to give the impression that Soviet psychiatry was no different from Western European psychiatry, the *International Classification of Diseases*, edition 9, 1977 (ICD-9) was adopted. However, it was altered to fit the Soviet framework and was therefore not the same diagnostic manual that the rest of Europe used. Key terminology was changed and there was a heavy emphasis on schizophrenia as a diagnosis where no other diagnosis was determined (Korolenko and Kensin 2002:60).

Psychiatric abuse persisted, despite the adoption of the altered ICD-9, but at a reduced rate, and in 1989 and 1991 the USSR permitted the Bureau of Human Rights of the US Department of State and the WPA to visit the country (Ougrin et al 2006: 458). In 1985, the policy projects of *perestroika* and g*lasnost* aimed to restructure and democratize the Soviet Union in addition to promoting more freedom of information and speech. Initiated by Mikhail Gorbachev, Perestroika decentralized control of industry and agriculture and allowed for some private ownership while *glasnost* allowed for greater accountability, openness, discussion and freer disclosure of information than was previously allowed. According to the president of the NGO that I worked with in Ukraine, these did have somewhat of a positive effect on the psychiatric hospitals because the openness created more transparency – people began to speak more freely about abuses. However this was short lived; with Ukraine's independence came many hardships.

In the early days of independence there was hyperinflation with the ruble and "miserable economic failure" (Åslund 2009:246). Hyperinflation also "wiped out the savings of millions of frugal, hard-working citizens," especially the elderly, leaving

millions of Ukrainians penniless (Subtelny 2009:620-621). While the majority of the citizens of Ukraine were plummeted into poverty, many elites were able to take advantage of the chaos and transformed party funds and property into private holdings, becoming wealthy oligarchs (Subtelny 2009). This sustained economic crisis lasted almost a decade and negatively impacted people's physical and mental health, and life expectancy (Lekhan et. al. 2004:6). In terms of everyday life after independence this has meant political and economic instability, as well as the resurgence of diseases such as "diphtheria, tuberculosis, and cholera" (Lekhan et. al. 2004:7). These along with diseases like HIV are spreading because of intravenous drug use, growth in commercial sex work, as well as the increase in unemployment and falling living standards (Lekhan et. al. 2004:8). These hardships greatly impacted mental health especially with regards to alcoholism; after independence Ukraine saw a large rise in cardiovascular disease and alcoholism, especially among men. In 2002 the World Health Organization (WHO) administered the first structured psychiatric interview in Ukraine to assess the prevalence of nine psychiatric and alcohol disorders. Their results were that "close to one-third of the population experienced at least one DSM-IV disorder in their lifetime… in men, the most common diagnosis were alcohol disorders (26.5% lifetime) and mood disorders (9.7% lifetime); in women they were mood disorders (20.8% lifetime) and anxiety disorders (7.9% lifetime)" (World Mental Health Survey 2005:2). They conclude that these estimates were higher in Ukraine than in comparable European surveys.

After independence in 1991 many reforms were introduced to Ukraine, many of which were the result of structural adjustment programs or austerity. Specific reforms

pertaining to mental health included the creation of a national policy on psychiatric care called the "Law of Psychiatric Care," enacted in 2001 (Renaissance Foundation 2005), and the "Mental Health Declaration and Action Plan" to which Ukraine committed at the WHO European Ministerial Conference in Helsinki in 2005 (Kuznetsov 2010). This declaration outlined a plan of action for mental health reform all over Europe, including Ukraine. These reforms reflect neoliberal ideology discussed earlier, such as patient responsibility for health and the banning of "labor therapy."

To make sense of what was happening and is currently happening in Ukraine regarding mental health I will first discuss neoliberal economic policy and its promise to combat poverty through economic growth by focusing primarily on privatization, deregulation, and decentralization. I argue that there has not been a radical break in Ukraine between the Soviet and postsocialist models or environment; because of transitional dynamics, including neoliberal economic reforms and attendant cultural, political and social norms, already existing problems, tensions, and contradictions are only being exacerbated. To make sense of this, I adopt a theoretical orientation from critical medical anthropology (CMA), also known as political economy of health, as well as ecological and interpretive approaches and discuss how these economic, political and ideological reforms can be understood with regard to mental health.

Neoliberalism in Ukraine – Combating Poverty?

Proponents of the dominant neoliberal perspective assume that the best way to combat poverty and inequality is economic development and growth through free market capitalism (Gershman and Irwin 2000:11). Over the course of the last forty years

neoliberalism, a theory of political economic practices, has become "hegemonic as a mode of discourse and …has become incorporated into the commonsense way we interpret, live in, and understand the world" (Harvey 2007: 23). Neoliberalism was not always the dominant economic theory; many (Roy at al 2007; Harvey 2007; LaHaye 2008; Horton 2007; Shakow and Irwin 2000) argue that it is a revival of key aspects of Adam Smith's 1776 work The *Wealth of Nations*, and specific notions of liberalism stemming from this work. At the time, Smith was challenging mercantilist doctrine and its emphasis on government control of foreign trade in order to build a wealthy and powerful state (LaHaye 2008). In order to achieve these goals nations were restraining imports and encouraging exports in order to amass capital – specifically gold and silver - in order to fund large scale military confrontations (LaHaye 2008). Smith instead "advocated for a minimal role of government in economic matters so that trade could flourish" (Horton 2007:1). Here trade initiated freely was seen to be beneficial to everyone (LaHaye 2008). With the end of large scale military confrontations, liberal economics became a popular form of economic policy and was maintained for around 200 years, until it was replaced in the 1930s by Keynesian economics. John Maynard Keynes argued that the Great Depression of the 1930's was a result of the unregulated capitalist economy. His economic policy argued that governments could avoid depressions in the future by means of social spending and by putting money into the hands of the working classes and poor who, unlike the rich, do not hold onto their money, but spend it (Shakow and Irwin 2000:53). This immediate return to the national economy in turn would "boost consumer demand, increase business sales, raise profits

and foster more investment to meet the increased demand" (Shakow and Irwin 2000:53). Instead of "trickle-down" economics Keynesian economics argued for "bubble-up" economics (Shakow and Irwin 2000:53).

It wasn't until around the 1970's that liberalism became popular again. There were several reasons for this change, for example, a significant recession occurred in 1973 followed by an oil embargo and oil price hike because of the Arab-Israeli war resulting in rising unemployment and accelerating inflation (Harvey 2007:27). The Chicago School, led by Milton Friedman, challenged the current Keynesian economic policies suggesting that in order to achieve full employment and optimal allocation of resources free market principles were needed (Shakow and Irwin 2000:53).

R.K. Roy et al. (2007) suggest that the revival of liberalism was also partly a Cold War reaction to Marxist-oriented central planning of the Soviet Union. They write:

> If we fast forward to the middle of the twentieth century, we see the world economy dominated by a bitter contest between two contrasting economic doctrines or contending shared mental models, the Marxist-oriented central planning approach of the Soviet Union and its satellites versus the market-oriented economics of the western industrial nations, with the third (developing) world being pulled, bullied and cajoled back and forth between these two poles (R.K. Roy et. al. 2007:9).

However, I do think it is important not to dichotomize (neo) liberalism and socialism. These systems are not unchanging and pure, for example, *perestroika* and *glasnost* contained elements of liberalism. Instead of two very rigid systems, what we really have are a range of elements, whose overlapping features highlight the tensions in both systems.

Neoliberalism, being a new variation of Smith's liberalism, differs in its emphasis on "global market-liberalism ('capitalism') and free-trade policies" (Roy et. al. 2007:9). It is argued that neoliberal policies will help combat poverty through the long-term benefits of sustained economic growth (Gershman and Irwin 2000:13). Some of the basic premises underlying neoliberalism are that "human beings will always favor themselves" (McGregor 2001:83) as opposed to their neighbors and the wider community, and that individual and familial responsibility hold precedence over public good and the community (McGregor 2001). This premise maintains that state provisioned public assistance in the form of social welfare programs (like food stamps or Medicaid in the U.S.) hinder individuals' creativity and competitiveness. Promoted as enhancing individual agency and problem-solving, neoliberal ideology touts values such as "private property, competition and emphasis on individual success measured through endless work and ostentatious consumption" (McGregor 2001: 84) and promotes "unencumbered markets, free trade and individual liberty" (Harvey 2007:22). R.K. Roy et al. (2007:5) suggest that not everyone agrees with these popular tenants of neoliberalism, however, and as a result there are actually several distinct but related "*neoliberalisms,"* most of which can be distinguished by the degree to which it would be appropriate for governments to intervene in markets (R.K. Roy et. al. 2007:8). However, "most share broadly similar philosophical positions regarding the superiority of the market mechanism over state intervention in sustained growth and tend to emphasize the principles of individual and entrepreneurial economic freedom ahead of more collectivist approaches" (Roy et al 2007:8).

With the goal of sustained economic growth, neoliberal policies focus primarily on three means: privatization, deregulation, and decentralization. Privatization essentially means that state-owned enterprises such as schools, universities, health care facilities, the media (radio and television), public infrastructures such as roads, and public transportation such as airlines, trains and so forth are to be sold off to private entities (McGregor 2001). The rationalization of this transfer from the public to the private sector is that enterprises run by the government are unacceptable interventions in the economy because the free market (competitive marketplace) should decide what and how to produce (McGregor 2001: 85). However, as Brezis and Wiist (2011:237) argue "mass privatization of an economy can itself lead to increased mortality, particularly where social capital is low, suggesting that caution is warranted in corporate globalization, especially in developing countries." This is because "the widening economic inequities within and between nations, associated with a poorly regulated free market and the growth in influence and power of corporations, harm[s] public health" (Brezis and Wiist 2011; 237). In particular, they identify the proliferation of multi-national corporations that externalize costs in order to maximize profits, accomplished through minimizing regulations. Brezis and Wiist (2011: 233) say that because of deregulation, industries are able to operate in ways that undermine public health, exemplified by pharmaceutical companies who "spend more on marketing than on research." Corporations, they argue, also have a tendency to suppress and misinterpret scientific evidence as well as hide adverse effects of medications to gain market advantage (Brezis and Wiist 2011:233), (which sounds very similar to the Soviet system, especially if you replace "corporations"

with “the state” and “gain market advantage” with “preserve existing power arrangements.”) This in turn leads to the promotion of drug therapies as opposed to life style changes or political responses to social challenges and maladjustment, as “social, economic, spiritual, psychologic, and educational problems are considered diseases to be treated in the context of mental health with agents promoted by pharmaceutical industries” (Brezis and Wiist 2011:234).

Deregulation, another means by which proponents of neoliberalism seek to achieve economic growth, is intended to enable the free market by “removing pieces of law that previously enabled government to deliver a service to the public or reworking laws so that more power is given to the private sector” (McGregor 2001: 85). However, this also means eliminating policies that protect the environment, human rights, or labor rights in addition to the justification of lay-offs, cutbacks, downsizing and so forth. Here profit is more important than people or communities, as McGregor (2001:86) writes: “Neoliberalists fervently believe that private market mechanisms (supply, demand, price) are more efficient than public ones because they generate profit and allow the benefits (choice, quality, accessibility) to trickle down to ordinary citizens.”

Decentralization, the third element in the neoliberal trifecta, is the transfer of power arrangements and accountability systems from one level of government to another, in particular, from central state power to provincial, state, municipal or regional governments (McGregor 2001: 86). This transferring power to local levels of government is thought to allow for a faster and more accurate response to citizens needs since local representatives are thought to be more familiar with and aware of local

conditions. It is argued however, in the case of healthcare that it can actually lead to less accountability and less visibility because these services are "often off-loaded onto smaller governments that do not have the ability or the money to offer the same level of health care service" (McGregor 2001: 86). This can lead to a health care system that is "inaccessible, undependable, and inefficient" (McGregor 2001: 86) and in turn justify the need for private health care. The result is a health care system that is couched in terms of supply, demand, and competition – available only to those who can afford it. The logic is that individuals are able to actively participate in their health care and are free to decide where their money should be spent (McGregor 2001: 87). Human misery then is defined as a "function of personal choices, and human misfortune is viewed as the basis for criminalizing social problems" (Giroux 2004:xviii). Again, we can see overlap since this description also fits with how the Soviet system responded to individuals who dissented.

When translated into economic policy, proponents of neoliberalism insist that poverty can best be alleviated through economic growth – which can be attained through the cutting of social service expenditures, a decrease in industry protection, the freeing of interest rates, the privatization of state-owned enterprises, and realistic currency exchange rates, all of which will reduce state intervention while increasing competition and investment (Shefner 2008:24). In addition to these policies, neoliberalism explicitly promotes what is called "developed capitalism" along with its assumed sociopolitical concomitants such as civil liberties and democratic institutions (Liu 2003:2). Policies reflecting the neoliberal agenda in Ukraine often promote "civil society and development" (Phillips (2005a:502) and "strategies to instill initiative, independence, and

Western-style individualism" (Phillips 2005b:254), in addition to privatization in the economic and health care sectors. Clearly, neoliberalism is more than just economic policy; it is imbued with social values and meanings that require the remaking of cultural orientations which are essential to the effectiveness of structural and policy changes. In other words, neoliberal economic reforms go hand in hand with specific organizational forms, socio-cultural norms, and political ideologies. Among these are the promotion of democratization and civil society.

Civil Society and Democracy a la Neoliberalism

I have tried to demonstrate that neoliberalism, while sold as economic policy, is much more complex; there is much ideological or cultural baggage associated with it. There is an underlying "hegemonic" or "naturalness" of power relations associated with a political or economic structure regardless of whether they are oppressive or unequal (Pratt 2007:9), and this is true for both the Soviet system and the neoliberal system. This means that in Ukraine the promotion of neoliberalism also means the promotion of democracy and civil society as necessary for neoliberal economic policies to be successful. The linking of democracy with free market economies began to occur after the Cold War and both were promoted by lending and donor agencies internationally (Paley 2002:437). Democracy and the free market go hand in hand (Harvey 2007:22) and neoliberalism is now a hegemonic discourse that tells us how to interpret, live in, and understand the world.

The style of democracy however, is very specific. In an analysis of the "anthropology of democracy," Julia Paley (2002:471) notes that the "United States is regularly taken as an unexamined standard-bearer for the rest of the world" (see also Gledhill 2000). She notes that during the Cold War "democracy" was deployed ideologically as the antithesis of Soviet communism and in U.S. foreign policy to justify counterinsurgency efforts, including combating political transitions in Latin America, Africa, Asia and elsewhere deemed threatening to the US interests (Paley 2002:473). She says that in the 1980's and 1990's, " programs focusing most often on promoting elections and strengthening civil society and 'good governance' were purveyed internationally by lending and donor agencies, with varying results" (Paley 2002:473). More specifically, it was US-dominated donor agencies such as the Agency for International Development (USAID) and the World Bank through their ability to lend money to developing countries (including post-socialist countries) that were transforming post-socialist Europe. Civil society was presented in these neoliberal approaches as central to liberalization and democratization (Cohen and Arato 1992) and the driving force behind transitions especially in Eastern Europe. Cohen and Arato (1992:ix) define civil society as being "the sphere of social interaction between economy and state… created through forms of self constitution and self mobilization…instituted and generated through laws, and especially subjective rights that stabilize social differentiation." Institutions with autonomy from the state and the ability to resist and criticize its policies, such as (some) churches, media and news outlets, schools and nongovernmental organizations (NGOs) were considered essential to democratization.

In postsocialist Eastern Europe because of the ability of civil society to use forms of "civil disobedience" such as strikes, boycotts, and mass demonstrations, observers identified these as vehicles for ordinary citizens to exert influence on political society and to ensure the expansion of rights and democratization of society through accountability to public opinion (Cohen and Arato 1992). NGO's flooded into post-Soviet Eastern Europe after 1991 with the intention to help with the loss of Soviet safety nets, such as health care, providing services where the state once dominated. There are over 800 registered NGOs in Ukraine today with a reported 2 million members. Of these, there are more than 20 national patients groups and over 100 local patients groups in Ukraine representing interests related to non-communicable diseases alone (Tarantino et. al. 2011:16).

When measuring civil society's growth and impact, NGOs are often conflated with civil society, where some scholars "equate the 'strength' of a given country's civil society with the number of NGOs" (Phillips 2005:499). Sara Phillips (2005) through her work with women NGO leaders in Ukraine suggests an alternative approach to understanding civil society. She argues that there are "positive personal benefits of NGO work," (Phillips 2005:499) but that a critical perspective is also needed as the "structures of power and inequality that constrain activists' agency and may ultimately undermine their efforts" (Phillips 2005:499). For example, writing about "social enterprise" that was introduced as a strategy for NGO's, she describes the difficulties of such an endeavor because of corrupt and violent bureaucracies, inadequate financing and the difficulty of balancing the demands of business and the social mission (Phillips 2005:255).

A question on the minds of many researchers is therefore whether civil society has been successful in helping Ukraine transition from an authoritarian state towards a democratic society. Robert Legvold (2008), a Marshall D. Shulman Professor Emeritus in the Department of Political Science at Columbia University and former Director of the Harriman Institute at Columbia University, has argued that in Ukraine "democracy is working." Other political science scholars of Eastern Europe (Diamond 2002, Way 2005) however, believe that authoritarianism is simply masked by new democratic language and laws. Paley (2002:471) warns against rigid definitions, saying "political forms are not neatly differentiable but rather complexly intertwined, and the discourses labeling certain regimes as democracies are strategically deployed by groups with strong interests in particular definitions and contested by others differently situated in relations of power." Writing about North Africa and the Middle East, Nicola Pratt (2007:14) suggests that without a "counter-hegemonic project," or a process in which the contestation of dominant ideas and practices would pave the way for an alternative or "counter" hegemony authoritarianism will only transition towards a "grey zone," where "countries occupy a diversity of positions between authoritarianism and democracy" (Pratt 2007:194). In other words, a strengthened civil society (and the range of economic reforms described above) is not enough to ensure a thorough transition from an authoritarian political and socio-cultural environment. Paley (2002) echoes this point in noting that "meanings attributed to democracy in various contexts and struggles do not necessarily match hegemonic definitions in actually-existing systems or even normative liberal democracy ideals" (485). Pratt (2007:6) writes that it was European colonization

which paved the way for authoritarianism in Algeria, Egypt, Iraq, Syria and Tunisia, and that authoritarianism, just like capitalism (or neoliberalism) is hegemonic. In order for these ideologies to become hegemonic it requires the participation of ordinary people who believe the systems they live within are "morally," and "naturally," appropriate (Pratt 2007:8-9).

Way (2005) says that in Ukraine discussions regarding regime transitions have focused only on "democracy" instead of authoritarianism. He feels that we need to look at the "factors that facilitate or undermine autocratic consolidation and regime closure" (232), such as national identity. Way (2005:240) describes how with the independence of Ukraine there came a divided character of identity, which was a result of "pro-Western" and "pro-Russian" conceptions of national identity. Pratt's (2007:9) work helps us to understand this even better; she says that authoritarianism continues to exist as a hegemonic system because it is not only underpinned by socioeconomic structures but also by cultural patterns that normalize it. In other words, just because citizens might challenge an authoritarian regime does not mean they are challenging authoritarianism (Pratt 2007:10).

While Pratt is writing about authoritarianism in the Arab world, her argument regarding the importance of "nationalism" or "national difference" to the strengthening of authoritarianism could also be important for Ukraine. She argues that the modernization projects of the Arab world helped to maintain authoritarianism because they were a reaction to previous years of colonialism; as a result these nations were attempting to distance themselves from foreign influence of past colonizers from the West (Pratt

2007:15). She says that in order to enable democratization, "civil society must wage a 'war of position' against authoritarianism," by creating a "new consensus that challenges the whole complex of socioeconomic, ideological, and institutional structures of authoritarianism" (Pratt 2007:189). It could be said that Ukraine is in a similar situation, except its past colonizer was Russia, not the West. Because of this I believe that Ukraine is in a much better position to enable democratization. The reforms of the mental health system are reacting to years of Soviet colonization and abuse. I believe however, that it is too early to say whether democracy is "working" or whether authoritarianism is being masked by new democratic language and laws. Instead, the data seems to support the idea that there is no "linear progression from authoritarianism to democracy" (2007:194); Ukraine is in a "grey zone," perhaps best captured in the term "postsocialist."

A related issue is the contradiction between neoliberal capitalism and democracy, where capitalism has increasingly become a threat to liberal democracy. Brezis and Wiist (2011:237) write that "it appears that capitalism, successful for investors, has become a threat to the important values of democracy, including education, culture, free competition, and public health." Where health and mental health are concerned this means that widening economic inequalities within Ukraine and between Ukraine and other nations, privatization, low social capital, a poorly regulated free market, and the growing influence and power of corporations will harm public health and social justice (Brezis and Wiist 2011:237). Interestingly, however, at the same time that there is an increase in social inequality, poverty and privatized health care, there have also been calls for and global support of human rights initiatives to address infectious diseases,

malnutrition, and access to affordable health care and medication. This could be understood as tautological or circular reasoning, where global capitalism and the free market are touted as a cure for poverty and other human rights dilemmas, but are at the same time a source of suffering and inequality as unequal access to resources are exacerbated by structural changes brought about by economic reform. Some have argued that this call for human rights hides the underlying capitalist and neoliberal agendas inherent in human rights rhetoric. Kirmayer (2012:109) writes that "the uses of human rights must be subjected to critical analysis as states accumulate new forms of power and surveillance and as transnational corporations assert their economic interests in ways that accentuate inequality and suffering." Another part of the debate here is whether human rights are universal or culturally relative, and whether group rights or individual rights hold priority in a given society (Kirmayer 2012:108). I believe this is especially important for Ukraine where historically individual interests were secondary to group interests, highlighting contradictions in human rights discourse that prioritizes individuals. He explains that not only should we be concerned with neoliberal agendas within human rights rhetoric, but also the "cultural assumptions built into psychiatric theory and practice" and "cultural imperialism," which results from the global export of Western psychiatric knowledge and expertise (Kirmayer 2012:108).

The current political-economic system that exists in Ukraine today contains elements of the Soviet system that are still at work in the mental health system. This is because of the ambiguous nature of transition itself, but also because of the common project of consolidating hegemony. For example, the Soviet system demonized

individuals, while the neoliberal one celebrates individuals; however, in both systems, the objective is to promote a particular totalizing vision, and the concept of the individual person is manipulated in to serve this goal. So, whether hegemony is consolidated in the name of socialism or neoliberal capitalism, individual needs are subordinated to the larger goals of the system and the elites who control it.

Medical Anthropology as Ecological, Interpretive and Critical

In my research I have chosen primarily a critical approach to understand what is taking place within the mental health system in Ukraine. However other theoretical orientations are drawn upon such as the Medical Ecological approach, as well as a meaning-centered or cultural interpretive approach. I believe my use of these theoretical orientations falls in line with Good's (1994:62) call for multiple perspectives:

> "Disease and human suffering cannot be comprehended from a single perspective. Science and its objects, the demands of therapeutic practice, and personal and social threats of illness cannot be comprehended from a unified or singular perspective. A multiplicity of tongues are needed to engage the objects of our discipline and to fashion an anthropological – scientific, political, moral, aesthetic, or philosophical- response."

From the Medical Ecological approach "health is seen as a measure of environmental adaptation" (Baer, et. al. 2003:32). In other words the level of health is a reflection of the quality of relationships between other groups as well as plants, animals and nonbiotic features (Baer, et. al. 2003:32). While my research does not look at the interplay between environment and biology, it does take into account the importance of "behavioral adaptations to health threats," or "socio-cultural adaptive strategies" (Baer,

et. al. 2003:33). For example, in my research I consider adaptive strategies learned under socialism, such as paranoia, caution and guilt to name a few. Here behavioral adaptations are learned responses to real threats such as famine, war and nuclear disaster. These adaptations however are no longer beneficial under the current postsocialist period and are instead maladaptive and redefined as mental illness.

Byron Good (1994) has written about the "cultural interpretive theory" or "meaning centered" tradition. This theoretical approach or model introduced by Arthur Kleinman defines disease as not an entity, or a part of nature, but as an explanatory model. Explanatory models are also cultural models and help to clarify how people make sense of their illness and their experiences of it, but these are only knowable through interpretive activities (Baer, et. al. 2003:36). Explanatory models can be elicited through open-ended questions, such as: "have you ever thought what caused your illness," "what do other people say caused it," "what else do you think can cause mental illness?" These are all examples of questions that I asked patients during my fieldwork in Ukraine.

One shortcoming of the ecological and interpretive approaches has been the inattention to power relations in the construction of clinical reality and for medicine's role in maintaining social dominance (Baer, et. al. 2003:26). Good (1994), as well as Lock and Scheper-Hughes (1996) have called for a blend of the critical and interpretive perspectives; they suggest that biomedicine should also be considered a medical system and not be exempt from cultural analysis (Lock and Scheper-Hughes 1996:42-42). This model suggests that all medical knowledge is a cultural construct.

The CMA approach, which is primarily utilized here, is useful for understanding mental health reform in Ukraine because it recognizes that health outcomes are connected to political and economic policies. This approach seeks to identify the "political, economic, social structural and environmental conditions in all societies that contribute to the etiology of disease" (Baer, et. al. 2003:53). Ember and Ember (2004: xxvii) have defined CMA as "the perspective that emphasizes that social and political factors (e.g. poverty, social inequality, discrimination, structural violence, toxic work environments) are important elements in understanding and treating health and disease." Proponents of this approach argue that disparities resulting from globalization and the expansion of capitalist markets through multi-lateral institutions such as the World Bank, the World Health Organization, and the United Nations have led to an increase in social inequality, poverty, and the marginalization of large sectors of populations throughout the world whose access to fundamental resources related to health and health care have been compromised. In order to understand macro level changes the CMA approach is particularly focused on the "wider causes and determinants of human decision making and action" (Singer 2004:24), primarily because focusing only on local level explanations has a tendency to distort or hide the structures of social relationships that unite… "and influence far-flung individuals, communities, and even nations" (Singer 2004:24). For example, Scheper-Hughes and Sargent (1989) have discussed the effects of the expansion of capitalist markets through the World Bank, WHO and United Nations and the effects on children and childhood. They describe how the 1970s were optimistic times; the World Bank and the International Monetary Fund (IMF) were extending loans to

countries to promote economic growth and development. However, these loans resulted in little improvement in the condition and life chances for the world's poor – especially women and children.

Similar trends can be found in Ukraine, where after independence the country suffered a severe economic crisis lasting almost a decade. After borrowing loans from the IMF and World Bank many Ukrainians began to sink deeper into poverty, while a few became wealthy oligarchs. This crisis negatively impacted people's physical and mental health and life expectancy. There were signs that things were beginning to improve before the financial crisis of 2008 with greater overall financial growth, however now there is a large gap between the rich and poor. In some sense, you could say neoliberal economic policies were successful, but as David Harvey (2007:22) writes regarding neoliberalism "it has succeeded in channeling wealth from subordinate classes to dominant ones and from poorer to richer countries." In 1999, 50 % of the population in Ukraine was living below the poverty line; there was a drop to 29 % living below the poverty line in 2001, and from 2003 to 2009 the percentage living below the poverty line has remained between 37 to 39 % (CIA World Fact Book 2013).

Equally important as macro level changes (wider structures or global processes) are the micro-macro connections (how wider structures and global processes interact with the local) – which links a patients' suffering to the global political economy (Baer, et al. 2003:29). Paul Farmer (2003), looking at Tuberculosis in Russia illustrates well the CMA approach to health disparities. He shows that in order to understand who gets sick and why we need to look at structural and political-economic conditions. His explanation

of why and who gets sick with tuberculosis in Russia is an excellent example of how the CMA approach highlights the structural and political-economic impacts on health and disease. He says that with the collapse of the Soviet Union, there were huge disruptions in medical care, many jobs were lost and people were pushed into crime to survive. Much of the prison population already had multidrug-resistant tuberculosis, so a prison sentence was in effect a death sentence. Because long-course regimens with second-line drugs are not cost-effective, only poorly performing short-course regimes of first-line drugs are used. Farmer argues that universal health care is a human right, and through his analysis of structural violence tuberculosis can be understood as a form of punishment. His analysis demonstrates that where you live, and your socio-economic status, can determine the quality of your health care thus linking political economy with suffering.

Erin Koch (2013:6-7) also writing about Tuberculosis but in Post-Soviet Georgia takes a close look at biomedical standardization, global health policies and more specifically, the DOTS (directly observed treatment, short course) approach to treating the disease. She explains how the implementation of the DOTS approach, taken as an unofficial requirement for national TB programs that seek financial and technical support, might actually be perpetuating conditions that sustain the disease instead of eliminating it (Koch 2013:6), in addition to how "social and political transformations affect medical knowledge production" (Koch 2013:9).

Also highly influential in the CMA perspective is the concept of "social suffering," or the collective and individual suffering shaped by social forces. Social suffering primarily affects those that are desperately poor and powerless. "The trauma,

pain, and disorders to which atrocity gives rise are health conditions, yet they are also political and cultural matters" (Kleinman et. al. 1997:ix). Joao Biehl (2007:348) writing about "Catarina," a woman living in a shelter in Brazil and deemed mentally ill and beyond all repair, shows how her "presumed psychosis was intimately related to changing political and labor regimes and to the pharmaceutical forms of knowledge and care embodied in the nets of relatedness and betrayals." She was tossed aside because she was no longer of value; in actuality, however she was suffering from a physical disorder called "Machado-Joseph Disease," which causes degeneration of the central nervous system (Biehl 2007:415). Caterina was misdiagnosed and thought to be mentally ill and as a result she was overmedicated with powerful antipsychotics and all kinds of drugs to treat the neurological side effects of which produced many of the symptoms (411). Biehl's findings are similar to what I found in Ukraine, where abuse of psychiatric patients is quite common because of the lack of medical surveillance and support networks resulting in an unstable environment that render patients invisible and beyond the gaze of the state (Bazylevych and Hresanova 2011:2). However, this is not entirely different from the kinds of suffering people endured when the state was in control of their mental health diagnosis and treatment under the Soviet system. While they were not "beyond the gaze of the state," they were beyond the gaze of their families and international standards for psychiatric treatment, therefore just as invisible.

Just as important to the CMA perspective are the interactions between individuals and medical technologies, science, and global forces. For example, globally dominant Western medical systems, more commonly referred to as "biomedicine," focus primarily

on human physiology (processes and functions of an organism) and human pathophysiology (breakdown of the biological system) which has a tendency to reduce disease to biology and devalues local medical systems and conceptualizations of health and illness (Baer, et al. 2003:11). For example, writing about the Chernobyl disaster, Petryna (2002) gives us another account of how social inequality and power are primary determinants of health and health care. Chernobyl changed the way that individuals engage bureaucracies and medical and scientific procedures as a matter of everyday survival (Petryna 2002:4). "Biology, scientific knowledge, and suffering have become cultural resources through which citizens stake their claims for social equity in a harsh market transition" (Petryna 2002:4). Petryna shows us how these new relationships to the state, resulting from the Chernobyl disaster, have produced what she terms "biological citizenship" (2002:5), where sufferers and disabled mobilize around their claims of radiation-induced injuries (Petryna 2002:5). Even the concept here of citizenship has been altered; no longer does being born in a state guarantee one's legal rights or guarantee health because "some persons born in other parts of Ukraine are arguably disadvantaged on the basis of intractable environmental and health threats" (Petryna 2002:7). More specifically, the role of science in the lives of Chernobyl victims dominate and in turn legitimate democratic institutions and "regimes of truth" (Petryna 2002:167); as well as "categorize scientific knowledge into 'official' versus 'unofficial' discourses and 'legitimate' versus 'illegitimate' science" (Petryna 2002:167). I would go further and say that science legitimates political ideologies more generally; and as a result is limiting access to health care. Earlier I identified how science legitimated authoritarian

rule under Stalin, and here is another common denominator between the Soviet and postsocialist eras.

The World Health Organization (WHO) "defines health as not merely the absence of disease and infirmity but complete physical, mental and social wellbeing" (Baer, Singer and Susser 2003:4). However, many medical anthropologists believe health is a cultural construct with meanings that vary depending on the society or the time period (Baer, Singer and Susser 2003:4). In other words, biomedicine is not acultural, instead it incorporates values, beliefs, metaphors and attitudes such as "self-reliance, rugged individualism, independence, pragmatism, empiricism, atomism, militarism, profit-making, emotional minimalism, and a mechanistic concept of the body and its repair" (Baer et. al. 2003:12 citing Stein 1990). The resultant hegemony of biomedicine where "capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment" (Baer et. al. 2003:14), has fostered a process known as "medicalization" (Baer et. al. 2003:14). Medicalization is a term coined by the sociologist Irving Zola, which in simple terms means assigning a condition or behavior a medical label, defining the problem in medical terms and then using medicine to treat it (Singer and Baer 2007:93). So, for example, medicalization takes problems such as stressful work demands, unsafe working conditions or poverty and transforms them from the level of social structure to one of an individual problem under medical control (Baer et. al. 2003:14).

Pharmaceutical companies have promoted medicalization through research, education and funding, by suppressing negative findings and exaggerating small benefits of new drugs (Kirmayer:2006:137), as well as "attempts to control the media and

regulatory agencies" (Brezis and Wiist 2011:232). It is also important to consider the strong influence that pharmaceutical companies are having around the world on contemporary medical education and practice (Kirmayer 2006:137). The reconfiguring of forms of suffering into, for example "indicators of conditions amenable to anti-depressant treatment" (Kirmayer 2006:137) are quite profitable for pharmaceutical companies, but can be quite harmful to individuals.

Much CMA literature often considers the hegemony of biomedicine and medicalization as arising out of capitalism and the West (Baer, et. al. 2003:40). This focus is not entirely accurate when we seek to apply CMA insights to contexts like Soviet and postsocialist Ukraine. Baer et.al. (2003:40) state that it was the profit-making orientation that caused biomedicine to evolve into a capital-intensive endeavor, where the state legitimized the corporate involvement in the health arena and reinforced it through training and research in a biomedical reductionist framework. While this is true for the West, biomedicine and medicalization were also evolving in the socialist East. For example, the Soviet practice of hospitalizing dissidents for isolation and discipline is one of the most notorious examples of medicalization (Kleinman 1988:10) where dissent was given a medical label and treated with medicine. The Soviet Union also medicalized women's bodies, particularly childbirth (Rivkin-Fish 2005a:24). Rivkin-Fish (2005a) writing about women's health in post-Soviet Russia says women's health in particular was medicalized through the heavy reliance on abortion and childbirth. She says that "women were characterized as ill, in need of expert control and technological interventions at all phases of pregnancy and birth" (Rivkin-Fish 2005a:25).

Medicalization has often been presented as a "humanitarian, objective, neutral purveyor of objective truth, neither affected by social and cultural processes nor implicated in regimes of power" (Rivkin-Fish 2005a:21). However, this is quite misleading as medicalization and biomedicine are used in both the capitalist and Soviet socialist contexts to "monopolize the means of production and maintain control over the distribution of social products" (Rivkin-Fish 2005a24). Moreover, medicalization and biomedical definitions transform victims into someone with a disease. Social experience is turned into a medical condition (Simms 2006:80). Jason Simms citing Taussig (1980) and Young (1980, 1990) says that "Pathologizing trauma assigns a type of blame for the condition, often on the suffer himself, making the patient responsible for his or her own illness" (80). This can lead to the delegitimizing of suffering. Finally, the medicalization of social behaviors helps to define what social behaviors are acceptable and normal. Increasingly medicalization is associated with modernity, where social arenas and behaviors such as stress, obesity, sexual impotence, alcoholism, drug addiction, smoking and childbirth are pathologized and transformed into an individual problem requiring medical control (Baer et. al. 2003:14).

In exploring these theoretical paradigms in Medical Anthropology and especially the way that CMA conceptualizes medicine, health, and illness I hope that I have shown how suffering is socially constructed as much as it is biological in origin. That there are political-economic forces that shape daily life and that the medicalization of suffering transforms it into an individual problem or disorder and ignores the social and political origins and contexts of traumatic response. Under both the Soviet and neoliberal systems,

biomedicine and discourses of science, and particular ideological constructions of the individual and his/her relationship to the state, society, etc. were utilized to legitimate the political-economic arrangement. I believe this falls in line with the CMA approach which says that political-economies and power structures shape health/illness. In the following chapters I will bring in the voices of patients, psychiatrists, social workers and activists working in Ukraine to bring greater depth to these arguments.

Chapter II

Structural Underpinnings of the Post socialist Transition

Advocates of mental health reform that I met in Ukraine, including members of the Ukrainian Psychiatric Association, have been pushing the government for more outpatient services. They are concerned with not only the current state of affairs regarding funding for state run psychiatric hospitals, but are also concerned with the well being of patients, many of whom spend much time as inpatients living in the state-run hospitals. They would like to see patients return to society and live at home instead of state-run psychiatric hospitals or at "psychiatric boarding schools" called *internatii.*

Internatii differ from state-run hospitals in that they are strictly specialized residence institutions for disabled citizens (Phillips 2011:61). *Internattii* are separated into four categories, "those for the elderly and disabled; for the disabled only; for 'veterans of work' with especially long and revered work histories; and for persons diagnosed with psychoneurological problems" (Phillips 2011:61). Once a disabled child reaches 16-18, he or she will be transferred to an *internaty* for adults (Phillips 2011:61). *Internatii* are "total institutions" intended as a "permanent residence" for those who require constant practical and medical assistance. Under the Soviet system, such care was framed as a right and optimal for quality of life (Phillips 2011:62). However, they have also been compared to "prisons and labor camps" (Phillips 2011:62). Several patients that I interviewed spent part of their time living between *internattii* and the state-run psychiatric hospital. While they did not liken them to prison or labor camps, they were

described as “homeless shelters,” or “adult orphanages.” This did leave me questioning what would happen if deinstitutionalization were to really take place in Ukraine. I imagine that it would be similar to what happened in the U.S after deinstitutionalization; that is, a rise in homelessness and higher prison populations.

The process of releasing patients and returning them to communities is known the world over as “deinstitutionalization,” and was pioneered in the U.S. in the 1970s and imitated, with debatable degrees of success, in Western Europe, North America and Australia/New Zealand (Fakhoury et. al. 2002). With the advent of medications, particularly antipsychotics, severely mentally ill people in these countries were no longer considered a threat to society. In the U.S. deinstitutionalization took place alongside the development of the “community mental health movement” enacted into legislation in 1963 (Kenig 1986:96). The idea was that instead of care being provided inside a psychiatric hospital it would come from an individual’s local community in the form of outpatient facilities for treatment, housing, food, transportation and any other basic needs for survival. So, while the push for deinstitutionalization in Ukraine seems to stem from the same set of issues that first influenced this process in the U.S., such as concerns about quality of care, the morality of institutionalization, and fiscal inefficiencies of long-term hospitalization (Friedman 2009:377), there are problems with deinstitutionalization in the U.S. that need to be considered.

Deinstitutionalization is fraught with many discrepancies as it is linked to the neoliberal agenda through its larger project to defund public sector services and move towards privatized care. For example, in my Master’s thesis research on community

mental health centers in Tampa, Florida, I found there to be a large gap in mental health services that can be linked to inadequate funding. This lack of funding affects cost, availability, quality, and quantity of services (Yankovskyy 2005:69). Also, because of the limited funding, much of the mental health budgets are geared towards "emergency stabilization," as opposed to preventive care (Yankovskyy 2005:68). So, while the move away from housing psychiatric patients in large state-run hospitals was suppose to provide better and more humane quality of care as well as financially efficiency, it has instead turned out to be just as inhumane and financially inefficient as long term hospitalizations. For example, in the U.S., deinstitutionalization was meant to provide a more humane system of mental health care – to end human rights abuses that were found in large, state–run hospitals. Instead the social and political changes associated with neoliberalism, such as deregulation, privatization and the focus on profit and consumerism have only strengthened private profit and corporate capitalism. As a result, the reality for many who are severely mentally ill is that they have been moved from hospitals to "homeless shelters, the streets, jails, and prisons" (NAMI 2002). I fear that similar trends will take place in Ukraine. Therefore I argue that deinstitutionalization, especially when coupled with neoliberal logic is by no means a "perfect" solution.

I believe there are a couple of reasons why mental health reformers are pushing for Community Mental Health Centers (CMHC) in Ukraine. First is the idea that these reforms are partly a reaction to Soviet injustice performed through psychiatry. Second, these reforms satisfy the neoliberal agenda to defund public sector services and privatize healthcare, and as such funding sources are central to the move to CMHC. For example,

during Soviet times, the effectiveness of the health care system (along with the allocation of funding) was measured by the number of "beds" and "physicians" – a focus that some believe sacrificed quality for quantity and encouraged lengthy hospitalizations (Lekhan et al. 2004: 15). This meant that the majority of the health care budget went towards inpatient care - up to 80%, with 15% spent on outpatient care and 5% for primary health care (Lekhan et al. 2004:14-15). With the independence of Ukraine in 1991 mental health reformers were particularly interested in combating this trend towards "more beds equals more money" and instead have been pushing for more outpatient services, which in theory would mean that funding would not be contingent upon "beds." Instead funding would shift towards social programs and local (community) public and private clinics, where private clinics would be competing for funding alongside public clinics. This vision is contingent upon the transition to mandatory health insurance which would help rearrange funding sources for patients and hospitals.

Currently, deinstitutionalization has not actually occurred in Ukraine, and exists only in theory, although I was told that funding has been decreasing to the state-run psychiatric hospitals. The realization of a community health model will pose significant issues for Ukraine. For example, as has been the case in the U.S. the majority of the mental health budgets are spent on "emergency stabilization." This is a result of the inadequacies of the separate delivery systems that are necessary for community mental health. In other words, the psychiatry hospital is "one-stop shopping," whereas community mental health means that patients have to search out separate organizations for help with medications, housing, transportation, food, clothing and so forth. A side

effect in the U.S. of the complicated nature of these services is that many individuals do without and only come into contact with services when there is a crisis, often brought in by law enforcement. This is not to argue that the state-run psychiatric hospitals provide better conditions, however it doesn't appear that either option is an adequate solution.

In the following sections I will address concerns and issues voiced by psychiatrists, social workers and other providers, as well as patients regarding these reforms that are associated with the transition from socialism and the influence of neoliberal arrangements. However, first I would like to discuss other forms of healing found both inside and outside the institutional setting.

Forms of Healing

In addition to pharma-therapy (medications), the state-run hospital also promotes other forms of healing such as psychotherapy, art therapy and work therapy (such as planting vegetables and flowers, weeding and general upkeep of the hospital grounds). The patients are also encouraged to learn crafts, such as stuffing mattresses and woodworking; however, as noted earlier, they are not allowed to sell their products because of new laws that prohibit the psychiatric hospital from this type of activity.

Aside from care found in the state-run psychiatric hospitals, there is a folk medical system that works alongside and separately from the state-run psychiatric hospitals. Sarah Phillips (2004:25-26) has studied women folk healers (*babky*) in Rural Western Ukraine and surmised that "Ukrainian *babky* carry out gendered performances that accord them a measure of prestige and power; complement and replace the system of

state medicine; act as psychotherapists; and specialize in psychosocial ailments to simultaneously heal persons and communities." She also describes how *babky* perform a kind of informal psychotherapy session by spending a lot of time with the patients, talking at length about their understandings of the problems faced, and about their past, present and future (Phillips 2004:28). This kind of psychotherapy might "allow the patient to re-connect with disturbing or traumatic events from the past and to reflect on the possible causes for his or her physical or emotional ailments" (Phillips 2004:28).

Although babkys are still important, and perhaps the only truly available "community mental health providers," most professionals dismiss their utility. The HRPP president describes different categories of patients and their interactions with both medical systems,

> "there are those that come voluntarily, those that are being brought, and those that have lost all hope after going through *Babushkas* [grandmothers] and *Dedushkas* [grandfathers], 'Shamans' and 'Witches' … different churches and things like that, and nothing works for any of them and after all that - they go to the doctor."

In fact, almost all of the patients I interviewed said they have at some point been to a *babky* for a consultation. One particular male patient that I interviewed felt that treatment with only folk medicine would be great and that folk medicine is far superior to pills. This is likely because of the socially supportive nature of the help delivered by babkys and their accessibility. It also raises questions about just how much "talk" therapy patients are receiving in the state-run hospitals. Because "charts" are confidential and patient's privacy must be respected, it is difficult to know for sure. I do know, however, that all patients except one were taking sleeping medications at night, followed by several

medications depending on their diagnosis. Many patients stressed their desire to be released from the hospital although they are there willingly and must continue treatment in order to be approved for disability, or to have their disability status continued.

This does seem to suggest that there is a huge emphasis put on the biomedical approach that sees illness located within the individual at the cellular level which can only be treated with medication. Therefore the social dimension to healing – such as "talk therapy" - has to be found outside of the institution. This does not seem unusual if you take into consideration that psychotherapy and counseling were officially forbidden in the Soviet Union and only state-managed psychiatry was permitted. Folk healing was also repressed during the Soviet Union, and if caught, the *babky* could have been arrested (Phillips 2004:23).

It is difficult to say how prevalent the use of folk medicine is today since it remains an unofficial healthcare option. However, most of the medical professionals that I spoke with said that their patients have probably seen a *babky* at some point – either being taken there by their relatives or of their own will, and almost all the patients that I interviewed admitted seeing a *babky*. Acknowledging the availability of alternative forms of healing that were not in line with the Soviet system is important because it highlights the challenges to the state and survival strategies that individuals took. Just as Rivkin-Fish (2005a:26) describes for pregnancy and childbirth, women in Soviet Ukraine confronted health care institutions with widespread distrust, which "emerged out of the contradictions between the state's ideology of providing humanitarian care and the

woman's practical experiences, rumors they heard, and expectations they developed of indifferent, incompetent, and uncaring treatment provided in health care institutions."

The Paternalistic Approach

Transitioning to community-based care in Ukraine has not really even begun yet, but in theory, this kind of reform seems like it could help improve the quality of care for those who seek help at state-funded psychiatric hospitals. For this reason, the mental healthcare providers I worked with generally supported such reforms; however many had their reservations as to how these reforms would actually work. Moreover, general reforms in healthcare (such as the "law of psychiatric patients") are perceived by practitioners as having positive effects, evidenced in part by the view of the head of a psychiatric hospital who noted that since the fall of the Soviet Union more people are turning towards psychiatry as opposed to folk medicine and the use of a *babky* or shaman, or no treatment at all. The head of a women's inpatient ward, located on the campus of the state- run psychiatric hospital described how she has much more freedom to speak with patients about everyday issues such as the side effect of medications. Such topics were frowned upon before Ukraine's independence, which could be attributed to cultural norms such as the emphasis on 'overcoming pain or weakness', a kind of 'stoicism', in addition to 'not complaining'. She also explained that even our interview would not have been possible during Soviet times because of the fear of outsiders, especially Americans, and the possibility of being labeled a dissident. A disability specialist described how, during Soviet times, "invalids" (a term used for people with many types of disability,

including mental illness) living on collective farms would receive no compensation or help; they were not even considered for disability status. A social worker and former patient from the rehabilitation center in Kyiv added that there was a policy to deny those on collective farms passports (the only acceptable form of identification so that one could travel within and outside of the country), which was intended to prevent these workers from leaving the country or the collective farm. People in the mental health environment were extremely limited in their options and highly dependent upon the authoritarian state, whose ideology denied any "weakness" in the population.

However, after 1991 this all changed; everyone, regardless of their position – from intelligentsia and collective farm workers to factory workers – could then receive the status of disability if needed. Depending on the level of disability, this status could include monthly payments (a living stipend), free medications, and bus passes for example. Reforms for those with disability status however are not without issues. Sarah Phillips (2011:239) describes the tension between empowerment narratives which promote individual independence and self sufficiency among the disabled in Ukraine, and the lack of state and community based support that are needed to make these ideals a reality. As a result the idea of "independent living" remains for the most part an unattainable reality.

While many practitioners feel that healthcare reforms more generally are having positive effects, these same practitioners feel that the country is not ready to transition to community-based services. The head of the psychiatric hospital, and the head psychiatrist of a women's inpatient ward, both felt that Ukrainians were not "mentally

ready," and that a wider change in people's attitudes towards psychiatry must happen first. This points to how the overall transition from the Soviet system to a postsocialist, or even neoliberal arrangement, requires a remaking of cultural orientations as much as structural and policy changes. This reluctance by the hospital staff to transition to outpatient care stems from their opinion that the population in general does not know what to do with family, friends, or neighbors who have a mental illness, and even if they do, they usually do not have the resources to help. They are especially concerned about the abuse of mentally ill patients they observed at the hands of family members, neighbors, police, and the state, as well as problems patients have in accessing quality medications and the lack of infrastructure that would make community-based care possible. As a result, the hospital staff I interviewed often took a paternalistic and materialistic attitude towards their patients. In other words, if we (psychiatrists or hospitals) don't take care of them (the patients) no one will – because society at large has no compassion, understanding, or financial ability to do so. This paternalistic attitude by psychiatrists towards their patients was also noted by Polubinskaya (2000:108), who states that this attitude needs to move towards partnership between providers and patients. The concept of partnership itself follows from neoliberal language, where patients are seen to be active agents in their care.

The head psychiatrist of the rehabilitation center run by HRPP suggested that the need for a change in attitude towards patients is understood but difficult for psychiatrists to follow, especially older ones. She reported that in Soviet times, the doctors and the patients' relatives would make the decision whether the patient was institutionalized or

not; the patient was never involved in the decision. Now, however, "we think of the patient-doctor relationship as a partnership, but it took time for me and my colleagues to realize this" The views of current mental health care providers are therefore significant as they highlight how the tension of transition from the Soviet system to neoliberal models is registered at the practical level of service provisions. Their own paternalistic orientation echoes that of the Soviet system, and their reflections on the lack of "mental readiness" of Ukrainians highlights how socio-cultural dynamics remain largely embedded in an earlier era of psychiatry as a mode through which repression was exercised and experienced.

Who's Responsible for Health?

Healthcare in Ukraine has been free for almost a century and was historically framed as a "human right" (Bazylevych 2009:67). As such, the responsibility for health was never in the hands of the individual or private providers but rather the state. The current reforms, however, are shifting this responsibility away from the state and onto the individual, and by extension, the family and community. Bazylevych (2009:68) has noted that the Ukrainian state administration, under President Yushchenko (2005-2010), emphasized "the responsibility of the individual and urge[d] Ukrainians to protect their health through… a healthier lifestyle… seeking out health insurance opportunities… and making more sensible use of the existing health care resources." On the other hand, there is also the public discourse that stresses "the responsibility for the nation's health on the Constitutional promises and the state's failure to meet them" (Bazylevych 2009:68). This

shift from the state to individual responsibility is a cultural dimension of the transition to neoliberalism and was not widely embraced by those I interviewed. Despite the way that a focus on "individual responsibility" differs from the Soviet approach, this transition actually seems to cement the paternalistic approach that psychiatrists often take towards their patients, thus demonstrating the contradictions that arise in such moments of transition. One psychiatrist, the head of a woman's ward, stated:

> "Many people refuse to take meds regularly because people think that if they feel better they don't need to take any more meds. It's an old Soviet mentality, *I'm not responsible for my health, let someone else be responsible.*" (Interview, April 2009)

The HRPP president voiced similar concerns regarding patients, noting that:

> "The mentality of people still has a long way to go. People are scared… they get used to their disease and start forgetting about their own responsibilities… [It is a form of] self-victimization." (Interview, December 2009)

The views of these mental health care providers illuminate how mental health, and approaches to treating it, are as much questions of culture and the construction of personhood and the self as they are questions of policy, practice, and provision. Significantly, health care providers are themselves implicated in these cultural transitions. We can also see how citizens are expected to restructure their health seeking behaviors, where they themselves are now responsible for their health. In other words, patients who do not take their health into their own hands are to blame for their poor health. Here bio-medical hegemony presumes self reliance, rugged individualism, independence, pragmatism, and so forth, values that are at odds with the Soviet model which advocates

for the collective and assumes. What must be considered however is that biomedical hegemony was also part of the Soviet model, but instead of the patient being responsible for their own health, the patient was expected to "submit obediently to the dictates of health professionals" (Rivkin-Fish 2005a:25). In both models, however it becomes the fault of the individual for either not taking care of themselves, or for not submitting to the health professionals. So, in both models the individual always subordinates to the larger goals of the system.

Infrastructure and Funding: Structural Discrepancies and Tensions

I will now shift my discussion away from ideological issues and focus on a few structural dilemmas associated with the transition from socialism (specifically infrastructure and funding), and how psychiatric care in contemporary Ukraine is not equipped to meet the transitions promoted by neoliberal reforms. When it comes to the state- run psychiatric hospital in particular, transitioning to fee-for-service or insurance-based care seems an almost impossible task. Before a transition such as this could take place, there needs to be infrastructure such as community-based services and support systems for patients. While there have been reforms for patients (such as the Law on Psychiatric Care) since Ukraine's independence that have had a positive impact, much work is still needed.

Lack of Community Infrastructure

For Ukraine, transitioning from a hospital-based system to community-based care, in simple terms, has translated into cutting the number of beds each ward offers with the

idea that the money that would have been allocated for that bed in the psychiatric hospital would be redirected to the community in the form of social services that help with medications, housing, and transportation. However, there are no "community" services or institutions available to redirect this money to, so despite reformers' best efforts, because of the lack of community infrastructure, or even a physical structure, this care (or money for care) is simply disappearing, or pocketed by corrupt politicians as is rumored. For example, in the villages away from the city centers there often are no services to be found for psychiatric care and patients must be transported into the city centers where the psychiatric hospital is located. While those who have been given the status of "mentally disabled" do receive free bus and trolley transportation, these services are not offered in the villages. As far as medications, even if a village has a pharmacy, one cannot be guaranteed that his/her medicine will be available, or that the patient can even afford it. The head psychiatrist of the rehabilitation center (located on the state-run psychiatric hospital campus, run by HRPP and houses HRPP's main office), describes this predicament:

> "Here you have access to a psychiatrist if you live in a city, they [patients] get the service they need, but what if you live in the country? It is too far from any kind of town. So the patient cannot get any services. So the patients are left to themselves and their relatives."

As a result, patients that live outside of the city often only arrive at the psychiatric hospital once they have suffered a crisis (as opposed to receiving preventative care), which results in lengthy hospital stays for stabilization and rehabilitation. Patients who do make it to the hospital often regard their time "in-patient" as a way to "get away" from difficulties experienced at home. There was much abuse reported at home; for example,

families taking disability payments or selling the patient's possessions, and physical abuse from the spouse and families. Some patients and psychiatrists see this abuse as acts of desperation on the part of the family members who are financially burdened. Many are unable to find jobs and, if and when they do, the pay is low and unreliable.

These patients find themselves in a similar situation to what Joao Biehl (2007) calls "zones of social abandonment," or what Dunn (2008) calls "stateless space," where abuse of psychiatric patients is quite common in many places because of the lack of medical oversight and support networks, resulting in an unstable environment where patients are invisible and beyond the gaze of the state (Bazylevych and Hresanova 2011:2). This emerging "stateless space" in postsocialist Ukraine is where NGOs such as HRPP are trying to fill in the void. HRPP in many ways exemplifies how civil society is envisioned to work – receiving funds from donor organizations such as USAID or the Soros Foundation in order to enact change locally and apart from the state. In the next section I will go into more depth as to the activities of HRPP and their role in structural and cultural transformations taking place in Ukraine more generally.

"Human Rights" and the Role of Non-governmental Organizations

The landscape of the mental health system is changing and NGOs have a large role to play. It seems only fitting that I would choose as my sponsor (not really on purpose however) in Ukraine an NGO insofar as these are forms of civil society are thought to be central to the liberalization and democratization of the country. HRPP is a local, patient-run NGO whose goal is to promote human rights for psychiatric patients as

well as help patients and their families navigate through stigma and abuse. The role they play in the lives of patients and families across all of Ukraine is significant. Also, HRPP, as well as other professional associations, such as the Ukrainian Psychiatric Association, are the leading voices in critiquing the current state of mental health affairs through participation in venues where they speak out on injustices and promote reforms.

In the early days of the HRPP organization, created in 1998, the goal was simply to help supply medications and to employ experienced epilepsy specialists. Soon afterwards the organization began educating patients and families about their rights, especially regarding the legal system. Patients and their families can now seek legal and medical help through HRPP. The organization responds to violations of human rights within psychiatric hospitals all over Ukraine, in addition to organizing press conferences to let the public know about issues in psychiatric hospitals. The organization is now focusing its efforts on "social work" and creating a "social work network," a discipline that has only very recently been introduced into Ukraine. HRPP believes that utilizing social workers as a medium to understanding the real-time needs of patients and their families will help to build the appropriate support and appropriately directed resources into the community. HRPP, in addition to training and incorporating social work into psychiatry, is also pushing the government for more monitoring of patients. As Phillips (2005) notes with respect to civil society and women's social activism in Ukraine, HRPP is also "struggling to stop up the gaps in the postsocialist state's crumbling social service infrastructure" (493). To quote the HRPP president:

> "These days, in order to protect our rights, we create our own team of human rights activists. They will study at the International Helsinki

> Foundation of the Protection of Human Rights... Our goal is to form a sufficient amount of human rights activists out of our patients that will be able to protect the rights of the patients in Ukraine" (izvestia.com.ua).

One powerful tool in the challenge to see a reformed and more humane system of mental health care has been the adoption of human rights language. This language is used as a way to critique the past and orient the present. The abuses of patients by their families and by others are a register of the tension and hardship resulting from the transition. Many families have not been economically successful in this "New Ukraine" (Phillips 2008) and are quite often unable to help and care for their mentally ill family members. Here, the language of human rights allows HRPP an effective way to point out and mediate these tensions originating from the "top" (i.e. economic and market based reforms and the existent and proposed reorganization of psychaitric services) that are being felt in the lives of patients and their families. This language also carries something over from the previous system (health as a human right), but at the same time critiques the abuses and failings of the previous system where patients were sytematically mistreated by the Soviet state.

If we look deeper, the use of human rights language itself registers a cultural shift. Human rights language (originating largely from the West and often attached to neoliberal discourse and reforms) emphasizes civil and individual liberties and political freedoms, whereas socialism under Soviet rule emphasized economic rights (such as the right to work) (Lambelet 1989:76). If, under socialism, the collective was the focus of importance over the individual – HRPP's focus on *individual* human rights indicates a shift – where the individual, along with civil and individual liberties is shown more

importance. However, HRPP faces a huge task: while the organization is protecting the rights of individuals by advocating in the court room, hospitals and in the villages, they are sometimes met with resistance, for example by the very family members of the patients that they are trying to help, especially when the outcome favors the individual, but not the family, such as a property dispute.

While HRPP is working to "fill in the gaps," the president of HRPP (my sponsor) is very concerned with how the reforms are actually playing out for practitioners and patients. For example, he states that "every year the IMF gives lots of money to Ukraine," yet he doesn't feel like he has that money. He is frustrated with the lack of funding that is available and the difficulties and challenges he must face to get what little funding there is. He is also frustrated with the implementation of these reforms, specifically the push for community mental health; he states that "the number of beds should directly correlate with the development of social [net]work, not just outpatient care, but it's not happening." He has his own vision of what this social network should look like:

> "There should be a strong center for medical-social rehabilitation that can see at least 150-200 people during the day with multi-disciplinary teams that will have social workers that represent the rights and interests of patients themselves, and advocacy groups. [A] Patient can come there and get everything he needs from that center. The branches of those centers could be formed in small districts of the whole oblast to try and solve the problems and needs of the patients. Working with individual groups and the groups of social help, and they need to be systematically taught about their rights, education, and lots of training sessions."

This vision is not terribly far from the promises that are made from the community mental health model (CMHM). It really seems to be a marriage of the best of what the

Soviet model offered coupled with some ideas from the CMHM. An important point here is his stress on "medical and social rehabilitation," as opposed to maintenance, or emergency care.

Lack of Funding

The psychiatric hospital during the Soviet Union did have many problems, as I have pointed out; however, funding was not typically one of them. The head of the rehabilitation clinic (located on the grounds of the state-run psychiatric hospital) described the psychiatric hospital of the past as a "self-sustaining community," where everyone's needs were looked after. The patients could work for some income, they were fed, and they learned viable trades. She went on to explain that, with Ukraine's independence came new reforms (not all are directly related to neoliberal reforms) that resulted in many improvements for patients, but also confusion. Before Ukraine's independence, she explained, the rehabilitation clinic itself was a great source of income for the hospital and for patients, who made fake flowers, including wreaths for funerals and parades, and sold their goods at a store in the mall. Due to new laws regarding "labor therapy," patients can no longer "sell" the products of their labor. This has resulted in a lack of funding and lack of activities for patients. She (head of the rehabilitation clinic) says:

> "There used to be more outpatient people, because they used to get a small compensation (salary) for their work, it was a very small amount but it still helped them out, even just a bit. The craft shops were on a self-sustaining basis (*hozraschet),* a form of management that existed in the old days. And now we only feed patients that are inpatient and the outpatient ones … we can't even get them some tea or a piece of bread because we

> do not have the resources, as it is rationed only per amount of patients that are registered as inpatient." (Interview, November 2009)

A patient I interviewed who was dealing with the death of her husband felt that many people do not need to be in the hospital. At the time of her interview she herself had been living in the hospital for more than six months. She stated,

> "There are plenty of people that need to be discharged. There are people here that could be doing things to help out around the hospital but they just sit and eat and that is it."

The head of the rehabilitation clinic explained how different rehabilitation activities are now managed, and how some things that have been changed due to reforms probably didn't need to be changed, because they were working for the patients and the hospital; for example, teaching the patients a viable trade:

> "Another thing is that the shops were independent, and did not fall under the management of the hospital. Now the shops are under the management of the hospital. In 2000 the staffing was changed due to a new law that has changed all that. According to the new law, the technical instructors that used to be personnel with technical education, now they were assigned to the nurses, the personnel with medical education. And I am sorry but not every nurse can put a thread through a needle more or less to make a new mattress. So you have this dilemma: do you teach the nurse to sew or to train in the medical field?"

One of the goals of neoliberal reform in Ukraine is to restructure government services by changing the budgetary model by transitioning to a health insurance model (Tarantino et. al. 2011:21), also known as privatization. For health care more generally this means giving more money to primary health care providers (PHCs) and promoting

PHC's over large hospitals. For the state-run psychiatric hospitals this means that funding will be cut and redirected to local community mental health centers (CMHCs). Whether this model might be successful or not however, hinges on the fact that there is currently a lack of infrastructure to support community-based care. So, while the state-run psychiatric hospitals are receiving less funding, there are no CMHCs, so at this point, care is simply disappearing. This situation, when combined with the law that prohibits hospitals from using "labor therapy," does protect individuals so that they cannot be taken advantage of by making them work for the profit of the hospital, but at the same time limits the financial solvency of the hospital. Without the income yielded by this labor, the hospitals are limited in their ability to provide for the patients because money from the state is not sufficient.

Another important aspect is that in the past work was indeed a form of therapy, or rehabilitation, which under the current reforms was redefined as infringing on the rights of patients. While I have classified this as a structural problem, the significance of funding can also be linked to a cultural shift from emphasis on the collective to that on the individual – and hence from economic rights (such as the right to work) to civil and individual liberties and political freedoms (Lambelet 1989:76). Here we can see how the philosophical and cultural underpinnings of the former Soviet system is in direct contradiction to the philosophical and cultural underpinnings of an emergent capitalism. To really drive home this point I believe a closer look at the morality of money in the Soviet context is needed.

Morality of Money

One of the philosophical and cultural underpinnings of the former Soviet system, as I have pointed out, is the emphasis on the "collective" vs. the "individual" and the relationship of the state to both. Catherine Wanner (2005:519) explains that "in capitalist societies, market competition renders certain individuals, professions, and industries redundant," however the "impoverished are held individually accountable for their failures." In the Soviet Union, "the state was the engine of social suffering and downward mobility for some and upward mobility for others. Status, wealth, and privilege potentially revealed more about an individuals' relationship to state authorities than about his or her abilities and achievements" (Wanner 2005:519). As a result "privileged consumption" (Wanner 2005:520) took on immoral connotations. Today, Ukraine's transition to economic practices which favor neoliberal logic and market arrangements are resulting in the unequal accumulation and consumption of wealth, all of which continue to be seen as immoral. As Caroline Humphrey and Ruth Mandel (2002:1) put it, "Ten years on, having survived Western market-oriented 'shock therapy,' taken on IMF and World Bank loans, and entered the global marketplace, the postsocialist societies still struggle to come to terms with the clash between deeply ingrained moralities and the daily pressures, opportunities and inequalities posed by market penetration."

Because healthcare has historically been universal and free to its citizens and framed as a human right, fees for services can take on an immoral characteristic. This is because it was and still is common practice to give unofficial payments as well as provide

supplies for the doctor; in other words, healthcare was never and still isn't *completely* free. For example, during my fieldwork in Ukraine I noted that patients were required to provide their own medical supplies, such as gloves, needles, gauze, and medications, to name a few. Additionally, doctor's salaries in Ukraine are very low compared with Western doctor's salaries (for example an average monthly salary would be 1000 *hryvnias*, which, depending on the exchange rate, is approximately $150 - $200 U.S. dollars) and not much more than other professions (such as a teacher, secretary, or accountant). State funds to the hospitals are likewise too low to provide adequate health care.

As a result of the low pay and economic insecurity among health care and mental-health workers and administrators, "corruption" is a persistent and systemic problem. The term "corruption," however, is not necessarily negative. For example, as Rivkin-Fish (2005b:10) describes for Russia, "doctors and patients strive to transform the public, bureaucratic character of the health care setting by personalizing it – replacing official, standardized protocols with the obligations and interactions of kinship and friendship," and this should not be dismissed as corruption "for they are often perceived by participants to be evidence of higher moral activity than many official practices." It is not uncommon for patients and physicians to practice *blat,* where doctors provide "special services to patients with connections" (Rivkin-Fish 2005b), and these special services would be paid for unofficially.

From a Western perspective, unofficial payments might be considered immoral and would probably be classified as "corruption," or at best as part of a "shadow

economy." But as Rivkin-Fish (2005b) explains, even during Soviet times, money as a form of payment was usually associated with corruption, and the only way to avoid corruption was to unofficially offer gifts. So, while money as payment during the Soviet period was viewed as immoral, as market reforms came into place and money became more common and acceptable, there was still the problem of making sure that "your" doctor would get the money. As money began to take on less immoral characteristics in the post-Soviet era, there was still a dilemma, as "Russians explained that official payments would most likely be consumed by hospital administrators, with the actual caregiver receiving at best only a small portion of the payment" (Rivkin-Fish 2005b:51).

In Ukraine, a similar fear seems prevalent that if fee-for-services were put into place, the money probably wouldn't be spent appropriately and/or would be pocketed by an administrator. As Rivkin-Fish concludes for Russia, "market reforms have not resulted in increased transparency in the institutional operations of health care services; informal information and personal acquaintances continue to be critical resources for learning about what one is entitled to, for figuring out how different institutions do or do not provide those services, and even for getting the basics of care fulfilled" (2005b: 63). It should be noted however, that Russia was the first post-Soviet country to adopt a national law on psychiatry in 1992 and has also adopted a national health care insurance system, while Ukraine is quite far from this. Based on interview data and my own observations, I found this objection to cash to be true in Ukraine; patients felt more comfortable giving a small gift directly to their doctor rather than cash payments. In the case of post-Soviet Ukraine, contradictions and uncertainties regarding the use of money

to pay for services mean that insurance-based care and fee-for-services arrangements in the healthcare field, instead of increasing transparency, might only reinforce the informal economy and are another way that the political-economic transition is registering culturally.

While I was conducting my fieldwork, the value of the dollar fluctuated tremendously on a daily basis – ranging anywhere from 5 to 8 *hryvnias* (UAH) to the dollar. Such extreme fluctuations in the value of currency lead many to trade in items or favors, such as a sack of potatoes or homemade vodka - items whose values remain more consistent. Thinking about this anthropologically, money might embody some of the most difficult transitions for Ukrainians, as it carries heavy symbolic weight in terms of differences between socialism and capitalism. Under socialism, individuals and families were entitled to services such as education and healthcare without paying fees, although, as discussed above, they might have given a gift of appreciation to the doctor. Institutions would trade services and industries would trade supplies, while the use of money as the basis for transactions was considered immoral due to the association with private profits and hierarchies of inequality under capitalist economies and social orders. More specifically, money was viewed as immoral because it was difficult to get and created a divide between those who had it and those who did not, violating the norms of socialism in which people *earn* entitlements, ideally, based on their hard work and good relationships with others. As a result, socialism in Ukraine is often romanticized because despite Soviet abuses, many individuals were much better off in terms of meeting their

basic needs compared to their status after market reforms that favor neoliberal capitalist agendas.

Diagnosing and Diagnostics: Westernizing the Understanding of the Human Mind

In the previous sections I have been discussing two specific reforms, the push for community mental health and insurance based health care. Now I will discuss the final reform that is much closer to being a reality than the previous two reforms – the adoption of the International Classification of Diseases, the 10 edition (ICD-10). The ICD-10 is a diagnostic tool used in many countries and is a product of U.S./Western based models for diagnosing and treatment of illness, and was adopted in Ukraine with its independence in 1991. Soviet practitioners however did have access to the ICD-9 as early as 1978 (Yevelson et. al. 1997:1552). As Yevelson et. al. (1997) have concluded for Soviet practitioners the ICD classification system was used "for diagnoses intended for official purposes or when collaborating with Western mental health professionals" (1552).

Historically, the Soviet model of distress differed from that of the West with respect to diagnosis and treatment. Generally, "they [Soviet psychiatrists] used categories of the National Traditional Classification (NTC) … a classification based mainly on the famous neurophysiologic work or I.P. Pavlov, S.S. Korsakoff, and V.M. Bechterof" (Yevelson et. al. 1997:1552). The NTC approach used "terms and categories from the old Russian classifications based on national traditions" and emphasizes a "nosologic approach" (Yevelson et. al. 1997: 1552). The difference between a nosologic approach and the Western phenomenological one is that the nosologic approach looks for

a direct relationship between cause and symptom, whereas the Western phenomenological approach places more emphasis on symptoms (Yevelson et. al. 1997: 1552). As a result there are differences in the classifications used by mental health professionals in Ukraine today. In my own research, I found that while many Ukrainian psychiatrists will say that they use the ICD-10 to diagnose and categorize mental illness, in practice many (especially older) psychiatrists do not use it.

The ICD-10 was heavily influenced by The Diagnostic and Statistical Manual of Mental Health Disorders or (DSM). Both manuals are large books that list different categories of mental illness, the criteria that should be used in diagnosing them, and a corresponding code. Both the DSM and the ICD-10 were closely coordinated so that the categories are relatively the same. The DSM in the U.S. "is required so that mental health professionals are able to receive funding from Medicaid, Social Security Disability Income, benefit programs for veterans, and Medicare" (Ericksen and Kress 2005:x). The same could be argued for the ICD-10. In other words, every person that a mental health professional sees gets a diagnosis and corresponding code number from the DSM or ICD-10. Several issues with these diagnostic manuals abound, one of which involves ethical concerns about the over-prescription of psychotropics especially when the financial incentive is factored in. For example, "drug companies provide substantial funding for conventions, journals, and research related to what is included in the DSM because what is considered diagnosable directly impacts the sale of their drugs" (Ericksen and Kress 2005:x). Additionally, Western models of mental health increasingly view the manifestations of suffering as biological disorders of the brain. Defining mental illness

as purely biological is supposed to help combat stigma (taking the blame away from the individual and placing it on biology, something they cannot control); however it is argued (Levin, et. al. 2004:95) that this definition only exacerbates the illness because a biomedical illness "carries with it a subtle assumption that a brain made ill through biomedical or genetic abnormalities is more thoroughly broken and permanently abnormal compared to one made ill through life events" (Watters 2010:173). Also, by conceptualizing mental illness as a biological disorder we are medicalizing suffering – often at the price of ignoring environmental and social causes. Again, however these same trends with medicalization were found in Soviet medicine as well, the only difference being that the pharmaceutical industry was owned and controlled by the Soviet government and therefore directly dictated the focus of research.

To utilize a diagnostic tool such as the ICD-10 in Ukraine (or any non-Western country), one has to assume that psychiatric disorders are universal and that one standardized diagnostic technique can be applied to all. Using this "one size fits all" approach requires one to ignore how culture shapes illness behavior (Kleinman 1988:47) and how "symptomatology of mental disorders differs very substantially cross-culturally" (Kleinman 1988:44). For example, schizophrenia, as Arthur Kleinman (1988) writes, is strongly conditioned by things such as unemployment and economic depression and capitalist modes of wage labor (36). He describes how many of the same negative symptoms of chronic schizophrenia are similar to those reported from long-term unemployment, such as "depression, apathy, irritability, negativity, emotional overdependence, social withdrawal, isolation, loneliness, and loss of self-esteem, loss of

identity, and loss of a sense of time" (1988:55). He says that when medicine is understood in light of socio-political circumstances it leads to the notion that much of human misery originates "from sociopolitical, socioeconomic, and sociopsychological affairs" (1988:61). So, in other words, the classification of stress and trauma (from real, not imagined events) as personality disorders with biological origins corresponds to political ideologies that view suffering as originating with the individual, thereby largely ignoring the role of history and environment, which was also an aspect of the Soviet model.

Jenkins and Barratt (2004) consider the role culture plays in the diagnosis of schizophrenia, as well as its chronicity. They state that Schizophrenia is probably "not a single disorder but more likely a number of disorders that are, for the time being, classified under one rubric" (Jenkins and Barratt 2004:2). Two interesting characteristics of the disorder are its remarkable variability, as well as its widespread distribution (Jenkins and Barratt 2004:2). They state that everyone is at risk; however those with lower socioeconomic status are more at risk, and "the association between schizophrenia and social class is one of the most consistent findings in psychiatric epidemiology" (Jenkins and Barratt 2004:2).

Biomedical concepts of distress medicalize suffering, which hides the fact that the origins of trauma might not be rooted in the mind. When stress and trauma are defined as rooted in the individual, this detracts from attention to larger societal forces endemic to Ukraine, such as extreme poverty, lack of access to resources and threat of cancer from radiation related exposures.

Medicalizing suffering is not a new concept to Ukraine however, as "both East and West share the incorporation of biologic and genetic research" (Yevelson et. al. 1997:1552). Lūse and Kamerāde (2012), looking at the changing attitudes of psychiatric patients in Latvia, argue that historically Soviet medicine and psychiatry saw illness and disability in a narrow and medical way, and related these to the inability to work, or loss of bodily functions (5). Psychiatric patients in the Soviet Union suffered two types of stigma: "co-citizens' stereotypes and another rooted in official ideology" (Lūse and Kamerāde 2012:6). People with disabilities were considered dangerous and a threat to the image of happy and productive Soviet citizens and therefore patients would find alternative ways to get medical help, such as unofficial appointments (Lūse and Kamerāde 2012:6). Unfortunately this is still a problem for Ukraine as the HRPP president describes,

> "there is …the problem of stigmatization. And that problem is that the relatives or the people themselves are scared to be considered or have their relative considered to be a psychiatric patient. Some patients come and consult illegally. For example, I have a child or a relative who has a psychiatric disorder and I don't want the neighbors to know about it because if they found out it would stigmatize [put a stigma on] the person and the family, so people go to a so called "independent consult." The last case I was in Kyiv the other day and I met my friend, who told me that he has a friend and would like to come and see the HRPP organization for an independent consult because they don't want to go to the psychiatric hospital."

The adoption of the ICD-10 and Western concepts of diagnosis and diagnosing will not provide much improvement in the lives of those with mental illness; in fact the continued medicalization or pathologizing of behaviors will only exacerbate their problems. This could be because both the Soviet and Western concepts of diagnosis and diagnosing

assume that by defining mental illness as biological it will reduce the stigma, but instead it is argued that it only reinforces the broken and permanent nature of mental illness as a disease. In the next chapter I will show how this reliance on biomedicine and use of medicalization is happening through the voices of my informants.

Chapter III

Mental Health Care, Diagnosis and the Medicalization of Social Problems

In the previous chapter I focused on the structural underpinnings of the mental health reforms in Ukraine. I would now like to shift focus to the cultural and ideological issues associated with these reforms more generally and especially the adoption of the ICD-10 which has a heavy focus on biomedical definitions of health and illness. The biomedical model, while not a direct stipulation of structural adjustment or austerity, is still in line with market reforms. However, as I have also shown, it was an essential part of the Soviet system as well. For this reason, it is a site where the tensions of postsocialist Ukraine are especially visible.

What's Ailing Ukraine? Diagnosing and Diagnoses

For diagnosing mental illnesses a key debate revolves around the appropriateness of applying the Western biomedical model cross-culturally (Kleinman 1988). Barber (2001), Keyes (1985), O'Nell (1996), Kleinman (1997), Young (1995), and Lock (1982), all question the cross-cultural applications of Western biomedical diagnostic and treatment options. However, their argument makes the most sense when applied to societies where biomedicine is not widely engaged. In order for this argument to make sense in the case of postsocialist Ukraine, however, we must broaden the concept of biomedicine to include the Soviet health model. In other words, biomedicine does not belong exclusively to the West; however the resultant medicalization is still the same.

The limitations of the biomedical model for Ukraine can be best understood when considering the role that historical trauma (of which Ukraine's history is full) plays in diagnoses such as Post Traumatic Stress Disorder (PTSD) (Whitbeck, Adams, Hoyt and Chen 2004; Tamar, Lavi and Solomon 2005). For example, PTSD in the Diagnostic and Statistical Manual IV (DSM-IV) is described as a single traumatic event. However as Young (1995) argues, traumatic memory is culturally shaped and therefore might not translate as a viable diagnosis in non-Western settings. (In light of my argument however, "non-Western" might not be the best word here as it does not include the Soviet model). Child development research as done by Garbarino and Kostelny (1996) and Hallis and Slone (1999), has shown that children who experience traumatic and stressful events while growing up may have developmental disabilities and may suffer mild stress to severe trauma, but that exposure to persistent trauma may well not have the same effects as exposure to a single traumatic event. Indeed, habituation to traumatic events may be an adaptive response to chronic stress.

As Lindy and Lofton (2001) describe, in Eastern contexts such as Ukraine, trauma and its reactions are "typical of the sufferings of most if not all" (Lindy and Lofton 2001:229); in other words traumatic experience becomes normalized. Historical episodes, or politically generated stressors, such as war, ecological disasters and economic crisis, produce behavioral adaptations in individuals and families, such as "caution, even paranoia, guilt and the inability to be free, dissimulation, splitting, self-discontinuity, intergenerational emptiness, and despair" (Lindy and Lofton 2001:xvi). Additionally, survival in an authoritarian context where documents were doctored, news

withheld, and those who complained were often condemned (Lindy and Lofton 2001:32) would require hiding one's feelings, making disclosure of personal issues difficult in a psychiatric context. These findings suggest that individual reactions to multiple traumas throughout Ukrainian history may represent a coping mechanism, or more specifically, learned responses to real threats. When I asked Ukrainian psychiatrists their opinions, many understood psycho-somatic illness to be an ongoing manifestation of historical trauma (such as the forced famine of the 1930's, WWII, and Chernobyl), now exacerbated by current struggles such as the economic crisis of 2008. For example the head of the psychiatric hospital when talking about PTSD said:

> "Well, you know everything depends on the situation; unfortunately we do not have a very fortunate situation. We do not have the stability that the country needs. And because of that you have all the Post Traumatic Stress situations happening, and don't forget we also have Chernobyl, that is still active, unfortunately. It also takes its toll on the flow of the psychiatric disorders."

The head of one of the woman's wards reworded my question regarding historical trauma, restating in the following terms:

> "Oh you mean if the stress of this generation relates and influences the stresses in other generations…? If the level of stress is psychotic then yes it can, it's my own observation and even if it's at the neurotic level. In a way it does. But it all depends on the living conditions and the environment of the next generations. The war in some way has affected [individuals], the death of loved ones, single parent families."

While having a universal classification and coding system for diagnosing illness may be desirable, because mental illness is not always completely biological, but also culturally shaped, a "one-size-fits-all" approach becomes problematic.

A few of the psychiatrists that I interviewed seemed to think that the ICD-10 is a better instrument than the ICD- 9 (the diagnostic tool used up until 1991) but putting it into practice has not been easy. The head of state-run psychiatric hospital feels that the ICD-10 is appropriate for Ukraine, but that any classifying manual does have drawbacks and the ICD-10 is not ideal. The head psychiatrist of a female ward who has 45 years of experience and teaches at a medical university still prefers the ICD-9 over the ICD-10. She says that for practical use the latter is not very helpful and that her lectures are taught using the ICD-9. She says that for her the ICD-10 is only useful as a reference. A disability specialist who is also a psychiatrist goes into more detail regarding the applicability of the ICD-10. He feels it is better than the diagnostic tools available during the Soviet Union, which he describes as being based on a "nosologic approach." As noted earlier, this type of approach is etiological, meaning it is based on the cause of the illness as opposed to the Western approach, reflected in the ICD-10, which is based on "symptoms." He says the switch to the ICD-10 has been the most difficult for older doctors; however he feels that symptom-based diagnosis is better in the long run for patients, especially since "cause" is not always known.

The emphasis on cause as opposed to symptoms might be based in cultural and ideological values specific the Soviet Union. Phillips (2011:54) writes that pain, suffering and disability during the Soviet period had to be presented in the framework of

dialectical materialism and war related mental trauma was understood as existing in the sufferer's body and physiologically (medically) based. She says this male-centric (and I would argue biological) nature of Soviet understandings of disability did not include women or children until *perestroika* since they did not fit the Soviet political-aesthetic project which favored war and work (Phillips 2011:57). This also seems to suggest that there was a political dimension to causes and symptoms.

Another difference between Soviet approaches to diagnosis and Western ones that the disability specialist I interviewed identified is the "permeable" nature of diagnosis. For example, if a person has at least one symptom of schizophrenia then one could be diagnosed under the Soviet system as "a little schizophrenic," but according to the Western approach this diagnosis is mutually exclusive; you are either schizophrenic or you aren't. The previous Soviet system enabled such a diagnosis because it allowed doctors to label just about anyone as schizophrenic, such as political dissidents, so that they could receive "therapy" in the psychiatric hospital. As explored in Chapter One, psychiatry in Soviet times was a very powerful tool of social control that ensured the survival of the system by discrediting, "getting rid of" or "taking care of" anyone that opposed the regime.

Authoritarianism and Suffering

Entangled with neoliberal structural reforms and the associated cultural tensions identified earlier, as well as diagnoses and treatment of mental health issues, are ideologies which shape definitions of normal and abnormal behavior. For example, in

the interviews I collected it is evident how the social effects of living under an authoritarian regime for decades shaped the texture of everyday life. This history includes dramatic crisis such as famine, war and nuclear disaster. But just as important are the everyday experiences of living under an authoritarian regime, such as social mistrust, the disintegration of families, displacement, detention, and the use of psychiatric hospitals for repressing dissidents. Living in such an environment lead individuals and families to develop behavioral adaptations necessary for survival, as mentioned earlier, things like paranoia and guilt, splitting and despair to name a few (Lindy and Lifton 2001:18). These behavioral adaptations were useful for coping and survival under Soviet rule, but now "contribute to difficulty in adapting to the changes after the break-up of the Soviet Union" (Lindy and Lifton 2001:18). Additionally, according to the ICD-10, these traits are considered symptoms of mental illness.

Take for example, the famine of 1932-1933, officially acknowledged by Ukraine as an act of genocide towards the Ukrainian population by the Soviet Union in 1991. While most people who were alive at the time have since passed, every year the famine is remembered through the media and with public memorials and marches. I personally sat in the audience with a group of Ukrainian high school students who were all shown the film "Golod 33," which traces one family from the beginning of the famine to their deaths. The former President of Ukraine, Viktor Yushchenko, made it a political goal to have the *Holodomor* recognized outside of Ukraine, and particularly in Russia, as genocide.

Figure 5 Lighting candles to remember those who died as a result of Holodomor (famine)

Because of the 1932-1933 famine (there were other less publicly remembered famines that took place in the 1940s), food and food scarcity is linked with historical memory in Ukraine. One elderly woman that I interviewed who was eight years old and lived in an urban setting in Ukraine in 1932 says she does not remember much about the famine, but does remember neighbors starving; she recalled a particular family to whom people would give food. Her son, who was also present during the interview, told me afterwards that he has known many people who continue today to hide food around the house in socks "just in case."

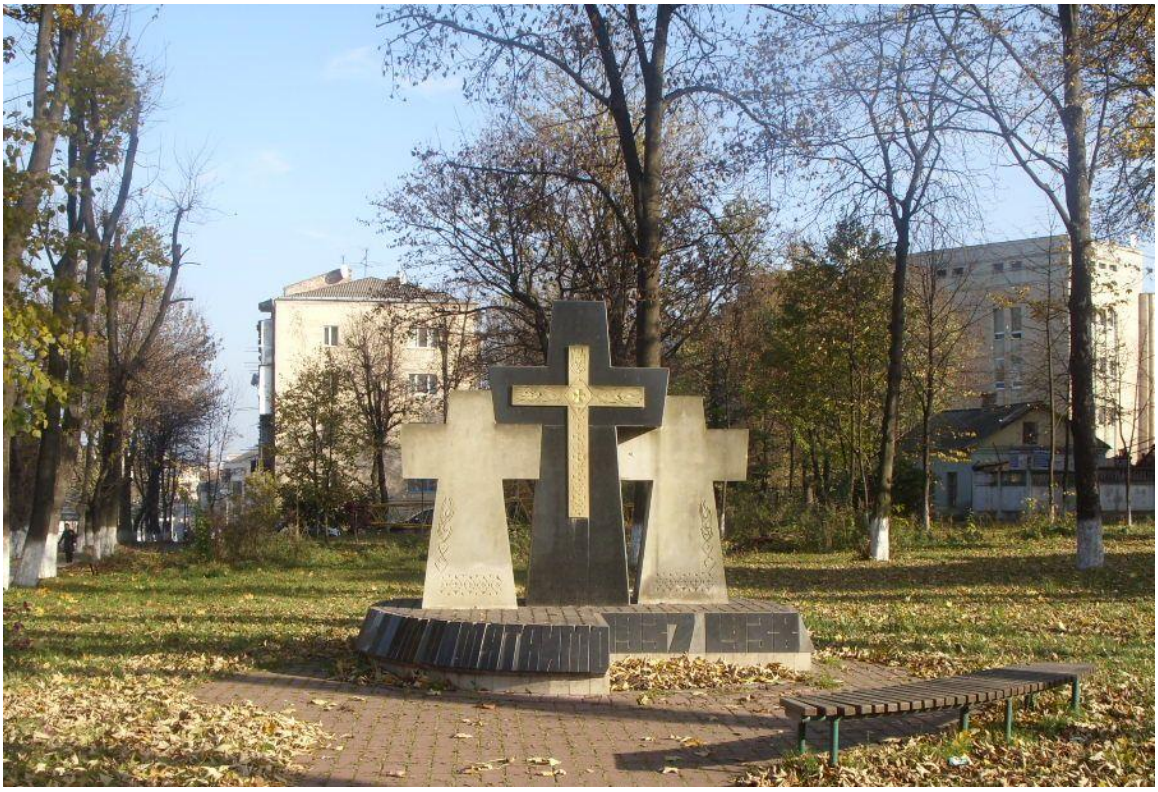

Figure 6 Monument to the victims of Holodomor (Famine)

Many people that I interviewed said that they believe the famine was not just in Ukraine, but all over the Soviet Union – that Ukraine was not specifically targeted. Regardless of how the famine is conceptualized however, most do agree that many people died in Ukraine and the difficulty for many that I interviewed is the knowledge that the families that survived were probably implicated in carrying out the "disastrous agricultural policies." This impact of the famine is rarely considered in the Ukrainian media. One of my interviewees, a disability specialist and psychiatrist summed up two

kinds of trauma that he sees resulting from the famine: trauma from knowing the horrors that took place and the trauma from surviving the horrors. He says:

> "Well, let's start from 1933. In 1933 a lot of people died, we know that for a fact. But the ones that died they are quiet; they will never say anything at all. The ones that died didn't have any children, he goes into the ground, that's it and you cover him up. The ones that have survived from 1933 they were always told, just like my parents told me - and that is where you are right - it was a mental trauma for the very little ones and we all know that very well. But in Ukraine there were not only those that died from the famine, in Ukraine there were also those that were creating the famine. Our people. They did give birth to children; they gave them education and so on. These people have a different kind of trauma because they understand completely that a horrible thing has been done, but there are more of those people. And they would not allow the other ones [survivors of famine] to tell this truth. So, here you have two kinds of traumas. So, some people want to tell the truth and others do not want the truth to come out. Nobody wants to have a grandpa that did such bad things. As my grandfather said, who was also a famine survivor, he said, in my house 'I did not have Stalin, Molotov, or Kaganovich, I had neighbors.' The famine was done by its own people. Our own people were making it."

His story highlights how shame and mistrust entered into intimate relationships because those who carried out policies that made the famine possible were not outsiders, but neighbors. This is exemplary of authoritarian tactics which pit different sectors of the population against one another, engendering mistrust.

While I was very interested in the affects of the famine on the Ukrainian people, it was often the memory of "World War II" or "The Great Patriotic War" as it is known in Ukraine that was more on the minds of people. Just about everyone I interviewed had a story to tell about the Great Patriotic War. Natasha, the secretary for HRRP not only survived the War, but was also "repressed." She described the events to me:

> "During the War I was in Kazakhstan. I was sent off because my father was repressed (sent to gulag) in 1938. The thing is that my father was the head engineer at a chemical factory and my mom was following him around. He was considered an enemy of the state. [In Kazakhstan] we used to go to the field and pick frozen potatoes. We would pick wheat. And back then for wheat grains you would get 5 years in prison. If you have collected some wheat and you were caught, then you would get 5 years. My mother, while we were gathering frozen potatoes, was seen by the watchman and was beat up so bad that she couldn't get out of bed for three months."

She then goes on to describe the conditions that her family was living in and the traumatic experience of war.

> "When we were leaving Novorossiysk . . . the whole city was burning and there was a railroad that was going between two mountains and that is where they would bring out the wounded and the German fighter planes would fly over and kill the wounded. And we would drop everything and start retreating… Germans would fly by again and shoot again. They would start shooting and everybody would drop everything and run to hiding places if it was possible. My grandmother always covered me up with her whole body. There was a lot - there were bodies and everything else was out there."

Natasha's story highlights the trauma of war and how it was experienced by a young child. Her stories speak of repression, social fragmentation and political suspicion. Behind her descriptions of the trauma she suffered there is an underlying theme of resiliency, heroism, perseverance and determination.

Figure 7 Parade to celebrate "Victory Day" which commemorates the Soviet victory over the Nazi occupation which ended in 1945.

These were common themes that accompanied stories I was told of WWII. Ukrainians that served in the war are quite proud of their achievements and often look on the war as terrible, but a time of great pride in what they achieved. It is because of this that I believe the Great Patriotic War was probably the most collectively significant event in the lives of Ukrainians and continues to shape lives today, especially regarding ideology such as issues of morality, justice and right and wrong. Murney (2009:163) gives an example of how WWII possibly affected gender relations where boys and even men in Ukraine are treated "like kings," possibly because so many men and boys died in

the World Wars. Another reason is that many survivors of the Great Patriotic War (WWII) are still alive, so there is a living memory. However, the numbers of survivors of the war are getting smaller and smaller. I personally witnessed a number of funeral processions for survivors of the War where the deceased is carried down the street in their coffin on the shoulders of men with family members, friends, and a small band of musicians (usually trumpets, trombones, or tubas) playing sad, long tones following behind. In this sense people are reminded weekly, if not daily of the passing of war veterans. A general I interviewed recounted:

> "I am in the Army since 1939, but in our schools, where I went to there was huge patriotism, we loved our country so much that we were ready to go and fight without asking questions. And only thanks to such patriotism we beat the Germans. At the time the German Army was the strongest Army in the world. And you see, in 1941 we were retreating, in 1942 we were retreating, but then we gathered together thanks to the Soviet power, you see it was all centralized. And that is why we defeated such a strong opponent." (Interview, December 2008)

His statement speaks of determination and resiliency and while he was not disabled, does seem to support Phillips (2011:56) findings that the model for the "New Soviet Man" after WWII was one that could not be represented as different but as "overcoming" (their pain or disability). Another example of the repercussions from the war that people continue to live with daily comes from the experience of a businesswoman who was about to be released from the psychiatric hospital. She recounted in an interview how difficult her and her father's lives were because her father was a German living in Ukraine. She described the impact that had on her growing up.

> "You know because my father was German, his whole life he has been followed and questioned, tortured; they would not let him work, express himself. So he killed himself. Since then I have realized that I am not like everyone else. I was nineteen. He jumped out of the fifth floor, right in front of my eyes. In one minute my hair turned grey." [Interview, December 2008]

It was these experiences resulting directly from WWII and further compounded by the economic crisis of 2008 that she attributes to her difficulty in Ukrainian society, her mental health issues and attempts at suicide. She described how before the economic crisis of 2008 she was actually doing quite well, she owned a

> "pharmacy, a grocery store and was I was building a 48 units apartment complex. Now I will not be doing so great, the dollar exchange rate went up 2 times against the hryvna. Nothing good…now since the crisis it will all go to the banks for the debts.

Here we can see how the transitions in mental health care are interfacing with her memories and historical dynamics: she had a breakdown and was admitted against her will by her family into the psychiatric hospital. However, while she says she did suffer in the past from her father's ethnicity and suicide, she had managed to do quite well after the independence of Ukraine by taking loans and investing in businesses. She was not in the hospital because of her father's suicide necessarily, but because of the relapse brought on by economic despair.

Ukraine's economic decline after independence, as well as the economic crisis of 2008 was and continues to be devastating for others as well. The loss of the social safety net provided by the Soviet Union for salaries, pensions, housing, and so forth made this economic decline doubly worse. The numbers do not really tell the story. I was able to interview a retired general, a veteran of the Great Patriotic War, who was deeply

disturbed by the changes he was seeing. Speaking generally for all veterans he described how changes after Ukraine's independence, in particular market reforms, were affecting the lives of everyone in Ukraine through low wages and inadequate pensions. He says:

> "The pensions and the salaries are very low… miners… teachers… doctors… people of the culture sphere [theater workers and such] have very low salaries and very low pensions for those that have disability. The minimum pension is 550 hryvnas [in May of 2008 the hryvna was 4.60 against the dollar, or $119.00, and in January of 2009 it was 8.80 against the dollar, or $62.00]. And now we have no war, the harvest is good, but still people are hungry. People are so electrified; there is a lot of unhappiness among people, negative attitudes toward the government. So, one big question that is scaring us right now is that there will be unemployment. So, you tell me, a young man not working, he has to live. A lot of criminals can start appearing [because of unemployment]. They will be stealing because somehow they have to live; it is a very dangerous story." [Interview, December 2008]

What connects these individual and collective histories is how social environment plays a role in mental health and vice versa. Social suffering, no matter its origin - war, disaster, poverty, or politics - is always imbued with culturally specific meanings. Shouldn't treatment and healing for symptoms arising out of such histories also be culturally specific? As Arthur Kleinman (1988) says, "by medicalizing [suffering] we deny the existence of social problems, or the darker side of major social transformations" (10), which is generally what the biomedical (or U.S.) approach does. However, the CMA approach unfortunately, is too Western-centric and too capitalist-oriented. These same insights can, however, be applied to the Soviet era, and specifically CMA's more general point that political economy shapes health, illness and treatment. To be most

useful cross-culturally, it needs to include socialist/authoritarian/Eastern models, not just capitalist/neoliberal/Western models.

As Kleinman (1988:3) puts it, "Mental illnesses are real; but like other forms of the real world they are the outcome of the creation of experience by physical stuff interacting with symbolic meanings." This means that the reform of the mental health system in Ukraine is not just about structural reorganization but it is also about cultural reorganization. Tensions from these reorganizations are registering culturally where people are being forced to restructure their health seeking behaviors, to call into question their relationship to the state, community and families as well as their morals, values and identities and to continue to frame problems as biomedical in nature. This process of medicalization disregards environmental and societal forces acting on individuals and communities. Moreover, medicalization or pathologizing behavior is carried over into all areas of culture. In the next section I will discuss how social problems arising from political-economic changes due to neoliberal reforms are also being addressed as behavioral issues, i.e. they are medicalized, and therefore can be treated in the context of the mental health system.

Social Problems and the Link to Neoliberalism

The transition to capitalism and a (global) market economy are registering culturally in other areas such as gender, poverty and environmental disasters, resulting in new social problems. For example, Riabchuck (2012:209) writing about the "crisis of masculinity" in Ukraine feels that the transition to capitalism may not have caused the

crisis, but it has affected the economic and psychological well-being of men, and that these are linked to social problems such as alcoholism and homelessness. She states that in Ukraine "de-proletarianization, unemployment, and lack of social security during a transition to capitalism are the main causes of poverty, alcohol abuse, crime and deviance" (Riabchuck 2012:206), which together have contributed to extremely high numbers of homeless men. Many of these individuals eventually end up in the psychiatric hospital at some point. Riabchuck (2012:208-209) describes this crisis as being further compounded by difficulties in the labor market where traditionally male-dominated sectors of the economy have shrunk, such as the military or machine building, and where available work is now found mostly in service sector jobs were women are more welcome as employees.

For example, one of the youngest patients that I interviewed, a 19 year old male with schizophrenia whose mother was also currently hospitalized with schizophrenia, felt that there were many people in the hospital who shouldn't be there. He stated that many people hospitalized for mental illness are only there because of financial reasons or because their families put them there, in other words they themselves and/or their families are too poor to take care of them. Whether their mental illness is real or a survival tactic, living at a psychiatric hospital seems like it would be a measure of last resort, which supports the idea that there is a trend towards medicalizing social problems such as poverty and homelessness. I am not trying to say that people are faking mental illness to get help in a psychiatric hospital, however because of the loss of safety nets previously supplied by the state many people are desperate and have nowhere to go. This

is similar to what Kleinman (1988:9) discusses with regards to the American disability system, where social problems such as poverty, unemployment and so forth are treated as medical problems and hence medicalized. He says this acts as a way to re-distribute income, something the U.S. society would not expressly authorize outside of the health care system.

While I did not interview anyone directly affected by Chernobyl or anyone who believes their illness is a result of radiation exposure from the meltdown, I did meet a family whose health problems are possibly linked to exposure from a nearby nuclear missile silo. Approximately two miles from their home, where they grow all their own food, sit five silos which until very recently housed nuclear missiles. The missiles were given back to Russia and the site was declassified in the late 1980s. Once the missiles were removed however, the silos were flooded with water. The mother of this family suffers from severe epileptic episodes and their son who was born healthy suffers from epilepsy as well as other disorders that kept him in a wheelchair until recently, and he currently is having problems because his brain is growing but his skull is not. In the interview with this family they described their problems in terms of the biomedical model, but also feel that it could have been the "evil eye," or *porcha* (cursed). Later in the interview, the empty nuclear silos were casually brought up as a possible cause. While this has not officially been labeled as a "disaster" or even acknowledged as an environmental issue, the families that live near this site have to live with the uncertainty of their own exposure to nuclear waste and its impact on their health. This uncertainty as to the causes of their illnesses creates tremendous stress. Here their inability to work,

poverty and health issues, possibly caused by environmental toxins are explained as biological in nature and originating within their bodies, hence medicalized.

Alcoholism is an interesting domain richly infused with cultural meanings that are not understood very well using only clinical explanations. The director of the psychiatric hospital discussed the exceedingly high rates of alcoholism in Ukraine. He believes that "because Ukraine produces so much beet sugar there has always been a lot of home brewing" and notes that "children that were conceived while drinking … have more pathologies than children with no alcohol." While I did interview several patients who were in rehabilitation for alcoholism, this was usually coupled with other diagnoses, such as schizophrenia or depression. I believe several factors are at play here for all of these diagnoses; one of these is historical trauma. One patient directly links her illness (she says she has been diagnosed with schizophrenia, however she says she does not hear voices and she does not suffer from depression) to her mother's and grandmother's experiences in the famine of the 1930's, and says she has passed on the "sickness" to her children as well. She said that she "inherited it from her mother" who inherited it from her grandmother. She was unable to describe the "sickness," however; she just stated that it has been passed down by the women in her family.

So far I have found two lines of thought or 'explanatory models' regarding historical trauma in Ukraine expressed by patients and providers alike. One is that Ukrainians are very strong emotionally, they have lived through famine, wars, and economic crisis and ecological disasters, and so they are much stronger than people in other cultures. Juxtaposing this is the idea that all these historical traumas – famine,

wars, economic crisis and ecological disasters - have weakened and/or killed off so many Ukrainians and only the strong or lucky remain. Certainly Ukrainians have found strategies for survival, such as not complaining, and for men especially, numbing their pain with alcohol. Alcoholism in Ukraine is a very large problem for the country and the psychiatric hospital. There is no doubt about the prevalence of alcoholism in Ukraine; people freely drink alcoholic beverages in public spaces and are often seen being carted away once they become drunk. In 2002 the World Health Organization (WHO) administered the first structured psychiatric interviews in Ukraine to assess the prevalence rates of nine psychiatric and alcohol disorders. Their results indicated that "close to one-third of the population experienced at least one DSM-IV disorder in their lifetime… in men, the most common diagnosis were alcohol disorders (26.5% lifetime) and mood disorders (9.7% lifetime); in women they were mood disorders (20.8% lifetime) and anxiety disorders (7.9% lifetime)" (World Mental Health Survey: 2005).

However my own observations lead me to believe that alcoholism is a socially induced behavioral manifestation of distress – a socially sanctioned activity with deep cultural roots – further promoted by poverty, not to mention a socially-sanctioned vehicle for men to talk about their problems. As Wanner and Dudwick wrote "vodka has enormous symbolic and practical importance in the culture and everyday lives of Ukrainians… In rural areas, homebrew *samogon* is so readily accepted as payment in a multitude of transactions that it is referred to as a 'freely convertible currency' (Wanner and Dudwick 2003: 267). They further point out that after 1986, "food prices in Ukraine soared, while alcohol remained affordable" (2003: 267). Additionally, alcohol

consumption can be viewed as enabling men to express emotion in a gender-appropriate manner, rather than appearing to complain or show stress, behaviors or expressions that would otherwise meet with social disapproval if displayed in the context of sobriety. For women however, alcoholism is viewed more harshly, for example Murney (2009: ii) writes that women addicts are seen as "consciously abandoning their femininity, their families and their nation," which means that they often do not seek treatment. While the abuse of alcohol can be seen as someone having an "escapist attitude" (Riabchuck (2012:215), I feel that a more fruitful understanding of alcoholism in Ukraine should recognize the influence of the structural rather than individual causes of alcoholism, just as Riabchuk (2012:218) concludes for homelessness.

Kleinman (1988:9-10) describes medicalization as an alternative form of social control, where medical institutions replace legal, religious and other community institutions as the arbiters of behavior. He describes how in the U.S. the American disability system medicalizes poverty, under-employment and worker alienation, which he says can be useful for social change since the disability program functions to redistribute income, something that (capitalist) society would not expressly authorize. However, the medicalization of behavior, health and social problems disregards environmental and societal forces acting on individuals and communities and transforms these into individual problems requiring medical control (Baer et. al. 2003:14). In other words, medicalization transforms victims into individuals with a disease, denying causes linked to larger societal forces, such as the restructuring of the economy, loss of safety nets, and so forth. Again, this is not particular to the West, as medicalization was also

used in the Soviet model of health care. However, neoliberal economic reforms are being touted as a way to restructure the economy so as to bring about positive change. My findings suggest that such reforms will continue to exacerbate tensions already present in postsocialist Ukraine.

Conclusion

The biomedical definition that mental illnesses are physical disorders of the brain is just not sufficient. Getting sick does not happen in a vacuum – health is greatly impacted by a myriad of factors, from political, economic, cultural and environmental in addition to biology. Changes in societies, such as the adoption of socialism in the Soviet Union, to the current promotion of capitalism and neoliberalism globally, influence and change health. Political-economic forces shape who gets sick, why they get sick, what they get sick with, and what treatment is available.

Ukraine and other postsocialist states are, and have been, in transition for many years, with the expected outcome being more democratic and capitalistic forms of government and market based systems. This expectation assumes a progression toward a natural, known, and specific end (Phillips 2008:83). As I point out, however these reforms in the political economy of Ukraine are producing cultural and structural discrepancies and tensions. In this dissertation I have focused on three particular areas of transition in the mental health field – the push for community based services, the move from socialized to privatized or insurance-based care and the adoption of the ICD-10. By grounding my discussion in the Soviet history of psychiatry and mental health care I show that these reforms are producing tensions between the socio-cultural underpinnings of both socialism and the transition to capitalism, such as how providers view their patients and where the responsibility for health lies. I also consider structural issues that exist with regards to the transition from the hospital to the community, such as the lack of

community infrastructure and funding. NGOs and human rights discourses – especially those which focus on civil and political rights of individuals as opposed to collective rights like health care – are exemplary of neoliberalism and its attendant cultural forms. HRPP, the NGO that I worked with in Ukraine is unique, however, as they utilize human rights language not only as a way to critique the past, but also to orient the present, allowing the organization a way to mediate these tensions arising from neoliberal reforms. I have tried to demonstrate how tensions from this transition from the Soviet system to the neoliberal-infused postsocialist environment are registering culturally and structurally in the field of mental health and in the lives of those with mental illness. However, this transition is about much more than the effects of neoliberalism; there are numerous nuances, contradictions and tensions as well as overlaps resulting from changing political economy.

During the course of my research I have tried to capture the perspectives of mental health providers, and advocates as well as the perspectives of the patients regarding the mental health system in Ukraine. I hope that by looking at the transition of the mental health system in Ukraine we might learn something about ourselves: that until as a nation we do something about social suffering and structural inequality, and until we adequately address poverty and the unequal access to resources, mental health problems will only continue to worsen. I believe future research is crucial, and there are several areas where our knowledge could be expanded. For example, Ukraine is not the only society to transition to the biomedical model, generally considered around the globe as the standard. Therefore research into other societies adopting biomedical models is

needed, as well as the continued monitoring of the changes in Ukraine. Additionally, expanding the CMA approach to include the Soviet model of biomedicine is needed.

In terms of envisioning a "moral economy," and/or working to mitigate the negative effects of neoliberalism, there have been suggestions that the "free market," instead of promoting "profit-driven health," should promote "value-driven health" (Brezis, et. al. 2011:232). McGregor (2001:88) calls it a "people-first philosophy," which has the intended goal of keeping society from becoming an appendage of the economy, where the rights of people come before the rights of capital. This is because corporate-controlled markets along with the excesses of capitalism pose grave challenges to social justice and the public as well as health and health care (Brezis, et. al. 2011:237). Finally, how do we mitigate the growing popularity of medicalizing behavior and its connection with corporate capitalism, especially expressed in the relationship to the pharmaceutical industry? Kirmayer 2012:108) writes that "psychiatry must see beyond its complicity with the pharmaceutical industry and other economic and political interests that encourage mental health professionals and patients to frame problems in ways that exclude the social origins of suffering" (Kirmayer 2012:108). Health and healing and the institutions such as Psychiatry that shape them are only as moral as the political-economy that binds them.

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Appendix

Appendix A

Interview Schedule
With Users of Mental Health Services

Demographics

Age? Sex? Religion? Which region do you live in? Where are you originally from? What is your nationality? What is your marital status? How many children do you have? What is your level of education?

I am interested in what you think about mental illness.

1. Have you ever thought about what caused your mental illness?
2. What are your symptoms? How long have you been experiencing them? Have you experienced any significant trauma or stress – recently or in the past? Do you see any co-relation with illness?
3. What do other people say caused it?
4. What did your doctor/doctors say caused it?
5. What do other people at the clinics say?
6. What else do you think can cause mental illness?
7. How do you feel about taking medications for mental illness?
8. What do you know about/what stories have you heard regarding the famine of the 1930's? WWII? Chernobyl? How have these events impacted you? Have these events impacted your health or your family members?
9. Do you feel you are getting better since you've received treatment? Worse? Do you feel that you can recover from your illness completely? If not, why not?
10. Do you know others with this same illness, or these same problems? Do you think it is a common problem in Ukraine? If so, for what reason?

I am interested in your experiences with mental health services

1. Please tell me your initial reasons for seeking services?
2. Have you been diagnosed with a mental illness? What illness? If so, when, and by whom? What have you been told about this illness? Do you agree with the diagnosis? If not, why not?
3. What subsidies are available for you? Such as living expenses, medications, or to pay for health services care?
4. Which ones are you using – are they helpful?
5. Do you need help with activities on a day to day basis? Can you explain?
6. Have you been prescribed medications for your illness? If so, which ones? Who prescribed them? What are they for? Are there Side effects? Are they effective? How long have you been taking them?
7. Can you afford your medications? If not – are you getting help?
8. How often do you have to take your medications?
9. Do others in your family suffer from mental illness? What illness?

10. Have you sought help from outside your local mental health services?
11. Have you every used traditional or alternative medicines/medical plants?
12. If yes, please explain.
13. Are friends and family supportive?
14. How often have you accessed care – is this your first time or a repeat visit?
15. Were you apprehensive to seek treatment? If so, why?
16. If you could change anything in the mental health system or treatment options, what would it be?
17. Is there anyone else you would suggest I speak with?
18. Are there any questions which I haven't asked that you feel are important to this topic?

Thank you for your time.

Appendix B

Interview Schedule
With Providers and Advocates of Mental Health Services

1. How would you describe your role within the system of mental health care?
2. What are your responsibilities; how long have you been in this capacity; what are your professional credentials and training?
3. What population(s) do you serve?
4. What are your objectives? Have you been effective in reaching these objectives? What is the most rewarding aspects of the job?
5. Are there any obstacles or difficulties in providing mental health services and treatment?
6. What are the greatest barriers regarding mental health services and treatment?
7. Can you explain how the mental health system is organized?
8. In what ways might an individual enter into mental health services (for example, voluntary admission, family) through emergency room? Primary care doctor?
9. Are there other forms of treatment that someone might seek out as opposed to mental health services or in addition to such treatment? Such as herbal remedies or treatments recommended by a healer in alternative or traditional medicines?
10. Do you commonly use medications in your treatment? Which ones? For which mental illnesses or psychological stresses? Do you feel they are effective? Do you use other treatments, such as psychotherapy? If so, are there any standards or limitations regarding how long a person receives psychotherapy? Do you feel it is effective? If so, in what way, if not, why not?
11. Are there other mental health services in the area? Are there other Primary health care services? Is there communication and cooperation between and among these agencies?
12. Have mental health services changed since Ukraine's independence? (In what way?)
13. Do you use the ICD-10 as a diagnostic tool? If not, what are your diagnostic tools?
14. If you use the ICD-10, have you found it useful and/or relevant?
15. Do you find that patients have trouble opening up/talking about their problems? If so, why do you think this might be?
16. What are the most prevalent diagnoses?
17. In your view, what are the different causes for different mental illnesses? Can you rank order the causes?
18. Many people are concerned about the effects of Chernobyl on Ukrainian health; in your view, have there been impacts of nuclear waste and/or radiation related exposures on health? And if so, what do you view these impacts to be?
19. In your view, has collective trauma of the past such as the famine of the 1930s, WWII, Chernobyl, Soviet occupation impacted the mental health of the population? In what way?
20. If you could change anything in the mental health system or treatment options, what would it be?

21. Is there anyone else you would suggest I speak with?
22. Are there any questions which I haven't asked that you feel are important to this topic?

Thank you for your time.

Vita

Shelly Yankovskyy was born in Oklahoma City, Oklahoma, on May 30th, 1975. She later moved with her family to Georgia where she attended elementary, middle and high school. In May of 1996 she received her Associates degree in Music from Darton College in Albany, Georgia and in 1999 received her Bachelor's degree from Valdosta State University in Valdosta Georgia. She began her Master's work at the University of South Florida in Tampa Florida in the Fall of 2002, graduating in the 2005. She was admitted into the PhD program at the University of Tennessee, Knoxville in the fall of 2006. Shelly Yankovskyy is married to Alex Yankovskyy, they have a daughter Nadia, born in 2003.